Blurring the Boundaries Between Midwifery and Obstetrics: An Exploration of the Role of Midwife Practitioner in a Maternity Unit In Wales

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Certificate of Research

This is to certify that, except where specific reference is made, the work described in this thesis is the result of the candidate's research. Neither this thesis, nor any part of it, has been presented, or is currently submitted, in candidature for any degree at any other University.

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ABSTRACT

This thesis explores the newly established role of midwife practitioner (MP) and its impact on midwives and obstetricians in a maternity unit in Wales. MPs manage the care of women at high obstetric risk and carry out aspects of care, such as assessment, diagnosis and the development of management plans, which in the past were predominantly performed by obstetricians. This qualitative study employs a focused ethnographic approach and uses a purposive sample. Phase one consisted of seven focus groups, which were held between May and August 2004, with midwives (n=48) from maternity units in Mid and South Wales. In Phase two, participant observation was undertaken with MPs (n=3) over a two-week period encompassing eight 12-hour night shifts, during November and December 2004. For Phase three, semi-structured interviews were conducted with midwives (n=10), clients (n=10) and obstetricians (n=7), between July and December 2005. Phases two and three were carried out in a maternity unit in South Wales.

The key findings of this study demonstrate that the lack of planning for the MP role inadvertently resulted in the creation of a distinct health care role, which encompasses positive aspects of both midwives' and obstetricians' work to provide safe and acceptable care for clients. The MPs in this study are committed to providing holistic care that takes into consideration the emotional and social needs of women and their families. In addition, these MPs are developing confidence and analytical skills, normally demonstrated by medical staff. However, further initiatives such as allowing MPs to prescribe, or to refer to other specialties, have not yet been adapted to support these new roles. It is too early to see the full impact of this role, but it is argued that it will have no significant effect on the work of the other midwives. MPs, however, do have the potential to impact upon the work of the obstetricians.

This study contributes to the current body of knowledge concerning policy and practice for maternity care by examining a new role early in its genesis. This study makes a number of recommendations, including extending the number of MPs employed in Wales, the need for careful planning of future extensions to the midwives' role and further research into the safety and effectiveness of the MP role.

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ABBREVIATIONS

ARM	Association of Radical Midwives
ANNP	Advanced Neonatal Nurse Practitioner
CMB	Central Midwives Board
CEMACH	Confidential Enquiries into Maternal and Child Health
EWTD	European Working Time Directive
ICM	International Confederation of Midwives
ICN	International Confederation of Nurses
IFGO	International Federation of Gynaecologists and Obstetricians
MP	Midwife Practitioner
MSW	Maternity Support Worker
MVP	Midwife Ventouse Practitioner
NAW	National Assembly for Wales
NHSE	National Health Service Executive
NHSME	National Health Service Management Executive
NLIAH	National Leadership and Innovation Agency for Healthcare
NMC	Nursing and Midwifery Council
NP	Nurse Practitioner
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
RCOP	Royal College of Physicians
UKCC	United Kingdom Central Council
WAG	Welsh Assembly Government
WHO	World Health Organization
WHPF	Welsh Health Planning Forum

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CHAPTER ONE – INTRODUCTION

The Ladies Defence
'Tis hard we should be by the men despised,
Yet kept from knowing what would make us prized;
Debarred from knowledge, banished from the schools,
And with the, utmost industry, bred fools.
(Mary, Lady Chudleigh, 1701, cited in Ezell, Ed., 1995)

1.1 Introduction to the thesis

This thesis explores in detail the role of MP, which was developed as a result of UK and Welsh health care policy recommendations, and the impact of such a new role on midwives and obstetricians in a maternity unit in Wales. In doing so, this study addresses the gap in current knowledge about this new practitioner in the arena of maternity care. Recent health policy recommendations, such as those offered in *Junior Doctors: The New Deal* (National Health Service Management Executive, 1991) and *Realising the Potential* (National Assembly for Wales, 1999), opened the debate on innovations in practice and have led to changes to the role and function of midwives. One of these changes was the development of midwife practitioner roles in Wales from 1998.

Midwife practitioner roles extend beyond the usual boundaries of midwifery practice, allowing midwives to manage the care of women at high obstetric risk and enabling them to carry out aspects of care most often performed in the past by obstetricians. These include operative deliveries and assisting at gynaecological operations, though there are variations in this role in different parts of the country. (The exact extra skills and functions of the midwifery practitioners in this study will be found in Appendix 3.) As well as varying functions, the new posts also carry various titles; however, they will be referred to in this thesis as **midwife practitioners (MPs)**.

Chapter one forms an introduction to the thesis. An overview of the history of midwifery is presented, followed by a discussion about the extended role of the midwife, and the general effects of UK and Welsh healthcare policy on nursing and

midwifery roles. The background to the development of the MP role, along with details of the study setting, are discussed and a description of the main roles referred to throughout this thesis is provided. The sources of data and the methodology employed are outlined and a reflexive account by the researcher is presented. Finally, the structure of the thesis is outlined.

1.2 The history of midwifery

To appreciate previous changes in the midwives' role and to set this study within its broader context, it is necessary to look at the past. This section provides a general overview of the history of midwifery and the role of the midwife (see Appendix 2). The history of midwifery was not recorded by midwives and has only been remembered and passed through generations by word of mouth or by the portrayal of midwives by the church or medical profession (Donnison, 1988). In the past, men wrote most textbooks on this subject, most ordinary midwives were illiterate, and so their experiences went unrecorded (Rhodes, 1995).

For thousands of years, midwives have helped women during childbirth, and the importance of their role was such that they were described in the Old Testament as examples of faith in God and of strength. During medieval times, midwives' knowledge was feared by the male-dominated church, which considered the possession of midwifery skills as evidence of evil. Evidence of any learning and a knowledge of the therapeutic use of herbs was enough to condemn a woman as a witch and a man as a sorcerer. Throughout this period, many midwives were burned as witches and the belief that midwives were both unclean and unfit to be present during childbirth was espoused by male-dominated institutions (Richards, 1995).

Eleanor Pead was the first midwife in England to be licensed by the Archbishop of Canterbury, in 1567 (Aveling, 1972). From 1567 until 1662, midwives were educated and licensed, however, in 1662 this stopped and midwives had only to pay a fee and take an oath for the Doctors Commons in order to practice (Masson, 1985). It was at this time that men became involved in the management of childbirth, prior to this, it was seen as work fit only for women. The first men to work in obstetrics were barber

surgeons who used instruments to extract the fetus. As the guild of barber surgeons made the use of instruments illegal for anyone outside the guild, midwives had to send for barber surgeons when, for example, a dead fetus was impacted in the birth canal. Midwives became co-opted by the licensing and incorporations of physicians, apothecaries and surgeons, and their ability to practise independently became constrained (Southern 1998). The informal training of midwives, mainly by the apprenticeship model, had been undertaken for centuries, but the formal education of midwives was first introduced at Queen Charlotte's Hospital, London in 1750 (Ridgway 2002).

Haslam (1996) cites examples of how nineteenth century midwives were portrayed in an unfavourable light in literature. He comments on Dickens' scathing portrayal of midwives in *The Life and Adventures of Martin Chuzzlewitt* (1843:4), where the character of the midwife 'Sairey Gamp' is described:

> This good woman would attend a laying-out and a lying-in with equal zest and relish.... The face of Mrs. Gamp, the nose in particular, was somewhat red and swollen, and it was difficult to enjoy her society without becoming conscious of a smell of spirits.

Midwifery regulation was achieved in England and Wales in the form of the Midwives Act (1902). The stated purpose of the Act was to improve the training and regulation of midwives (see section 2.2.1). Historically, midwives provided care for all women during childbirth but the Act stated that midwives could practise only if they were certified, and the certification was for normal parturition and neonatal care only. Following the Act, midwives practised under the control of the medical profession, and throughout the twentieth century, the midwives' role was altered as a result of the increase in the medicalisation of childbirth (Stevens, 2002).

During the twentieth century, obstetricians gradually increased their control over maternity services. The establishment of the National Health Service (NHS) in 1948 saw the development of centralised obstetric units (Leathard, 1990). In addition, the percentage of hospital births rose from 15% in 1927 to around 65% in the 1950s (Warriner, 2002). The increase in hospital births in the UK was accompanied by a reduction in maternal deaths during the twentieth century, as reported in *Why Mothers*

Die 2000–2002, the Sixth Report (Confidential Enquiries into Maternal and Child Health, 2004). It was only later that the connection was made between the reduction in maternal mortality rates and improved housing, sanitation, antibiotics, and the introduction of the NHS, rather than place of birth (Duff, 2002).

> The history of modern medicine in overall terms is that just as it was not responsible for the elimination of infections in the nineteenth and early twentieth centuries so it has had very little impact on the death rate since then. It has had considerable impact on the sickness rate from certain ills, but only limited success in the case of others, particularly those, which are the most common amongst us, such as tooth decay and digestive disorder. (Kennedy, 1981:25)

The Peel Committee (Department of Health and Social Security, 1970) recommended that 100% of births should take place in hospitals, on the grounds of safety, in spite of the fact that there was no apparent evidence supporting this. Despite this lack of evidence, the report was highly influential and by the end of the 1970s the percentage of hospital births had increased to 80.8% (Currell, 1990). As a result, the care provided by midwives became fragmented and midwives worked within a limited sphere of specialisation, in line with the medical model of care and under the direction of obstetricians. During this period, there was an increase in the medicalisation of childbirth, and midwives continued their loss of status as the general providers of maternity care.

The 1980s saw growing demands for improvements in maternity services from midwifery and consumer organisations. The most notable consumer organisation was the Association for Improvements in Maternity Care (AIMS) which began its pioneering work by instructing lawyers in relation to perceived cruelties to women. AIMS remains active and potent today. The Association of Radical Midwives published their proposals for the future of the maternity services in *The Vision* (ARM, 1986). The same issues were highlighted by the Royal College of Midwives (RCM) in *Towards a Healthy Nation* (RCM, 1987). These documents advocated one to one care, woman – centred care and an increase in homebirths. Since that time, there has been a climate of change in maternity services.

In the early 1990s, reports such as *The Protocol for Investment in Health Gain, Maternal and Early Child Health* (Welsh Health Planning Forum, 1991), *The Winterton Report* (House of Commons, 1992) and *The Changing Childbirth Report* (Department of Health, 1993a) called for women to have choice in, control of, and continuity from, maternity services. Throughout the 1990s, the midwifery profession began to reclaim its role as the main provider of maternity care and supporting midwives to work as the lead professional for women at low obstetric risk.

During the 1990s, some of the changes in the organisation of midwifery services, made to meet these recommendations, left many midwives dissatisfied with their role (Sandall, 1997). As a result, many midwives have left the profession, and recruitment and retention remains difficult (Ball *et al.,* 2002). Ashcroft *et al.* (2003) highlight the risks to the safety and effectiveness in the care of mothers, as a result of staff shortages and the inappropriate deployment of midwives, both of which have resulted from changes to provide woman-centred care. It appears that not all of the 1990's changes, such as the introduction of team midwifery to provide continuity of care, have been of benefit to midwives. Indeed, some have put extra pressure on midwives and may be seen as having had a negative effect on the midwifery profession.

The recommendations of such policy documents as *Junior Doctors: The New Deal* (NHSME, 1991), *Hospital Doctors: Training for the Future* (Department of Health, 1993b) and *The Working Time Regulations* (NHSME, 2003) provided opportunities for midwives to extend their role in new ways, carrying out duties traditionally undertaken by doctors and working as MPs. On first sight it seems that the main impetus for change was simple expediency, the doctor's hours and training programmes were changing and others would have to fill gaps. However, these developments were not entirely unwelcome and initiatives were encouraged by documents such as *Midwifery: Delivering Our Future* (DoH, 1998). This report suggested that midwives should develop their role in different ways, with some midwives providing all care for low-risk women, with others developing technical expertise to care for women at high obstetric risk alongside obstetricians. *Making a Difference* (DoH, 1999) opened the debate on innovations in practice and *Realising the Potential* (NAW, 1999) called for the development of existing (and the creation of new) career pathways for nurses, midwives and health visitors.

When considering the recent history of the midwifery profession, it appears that few of the changes resulting from health care policy have been of benefit to midwives. If midwives are to develop their role successfully in the future, there is a need to establish what midwives themselves consider are the aspects of care that lie at the centre of their role and are essential to it. It is vital that as many aspects as possible of the extended role of midwives are assessed to encourage good practice and establish an evidence base for further developments in midwifery practice. Though other studies have examined aspects of the extended role of the midwife – such as undertaking ventouse deliveries and neonatal examinations (Rajkhowa *et al.*, 1995; Bjuresten *et al.*, 2003; Townsend *et al.*, 2004 and Lumsden, 2005) – the current study is the first to explore the role of the MP, as well as its impact upon midwives and obstetricians in a maternity unit in Wales.

1.3 The extended role of the midwife

This section discusses the extended role of the midwife. In response to the opportunity provided by *The Scope of Professional Practice* (United Kingdom Central Council, 1992), midwives have been expanding their scope of professional practice to develop specialist skills (Kaufmann, 2001). The public health aspect of the midwives' role has increased – for example, in dealing with domestic abuse – in response to such documents as *Why Mothers Die 2000–2002* (CEMACH, 2004). This document recognises that social disadvantage is likely to increase individual risk during pregnancy, as did the *National Service Framework for Children, Young People and Maternity Services* (Welsh Assembly Government, 2005), which acknowledges that there has been a significant increase in low birth weight babies born in Wales, with the resultant reduced chance of survival in infancy and the increased risk of these babies suffering from chronic disease in adulthood.

While some midwives have extended their role in relation to public health, others have developed more technical expertise to undertake such procedures as vacuum deliveries (see Appendix 1). These developments in midwifery practice have been designed to improve maternity care for clients and career prospects for midwives. However, there are currently concerns about the recruitment and retention of

midwives within maternity services, and questions have been raised regarding whether staffing levels will be further depleted by the development of specialist roles.

> At a time when many maternity units are experiencing significant and prolonged recruitment and retention difficulties, why do some midwives feel they must say yes to demands placed on them to undertake tasks outside their role and responsibilities? (Jackson-Baker, 2000:117)

In addition, there is a risk that by taking on work formerly carried out by others, midwives might do so to the detriment of other aspects of care that only they can provide.

The Scope of Professional Practice (UKCC, 1992) stated that midwives could cross professional barriers to improve care and that midwives were allowed to extend their role to undertake duties that had previously been carried out by doctors. By extending their role, midwives may be able to practise autonomously and recapture their professional identity as the main providers of maternity care. This has resulted in the demarcation lines between the roles of obstetricians and midwives becoming increasingly blurred. There is considerable debate within the midwifery profession about this extension of the midwives' role; some feel it is a positive step and that midwives should acknowledge their responsibility to provide all appropriate care within their area of competence (Hartley, 1997; Mulholland, 1997). Conversely, others are concerned that such a move may result in midwives being exploited by the medical profession, whereby they would become technicians or assistants to obstetricians and lose all that is valuable and distinctive in the philosophy of midwifery (Jackson-Baker, 2000; RCM, 2002). However, there are no legislative limits to the activities midwives can perform, as long as they have received appropriate training and have the required skills to carry out the procedures at hand (Dimond, 1999).

For approximately ten years, midwives have extended their role by undertaking vacuum extraction and there have been a number of papers published on this topic. Rajkhowa *et al.* (1995) undertook a regional postal survey to ascertain whether midwives and obstetricians thought that midwives should conduct ventouse deliveries. A questionnaire was sent to obstetric consultants (n=81) with a response rate of 63%,

senior registrars (n=12) with a response rate of 8% and midwives (n=41) with a response rate of 29%. The study found that participants thought there was a demand for midwife ventouse practitioners (MVPs). Papers have been written describing the establishment and audit of MVP schemes (Hayes, 1997; Tinsley, 2001; Wills and Deighton, 2002), the schemes reported have been successful and the audits positive. There are also papers describing what it is like to be an MVP (Parslow, 1997; Charles, 2002). These not only acknowledge the professional debate about MVPs, but also describe this development of the midwives' role as being positive for both midwives and women.

Simms (2005) examined the issue of midwives undertaking neonatal examinations and concluded that this may improve the quality of care provided to the mother and baby. Lomax (2001) commented that, with appropriate training, midwives would be in an ideal position to provide holistic care for the neonate as well as the mother by performing the neonatal examination. A study by Lee *et al.* (2001) concerning nurses undertaking neonatal examinations found that nurses were more effective in detecting abnormalities than trainee paediatricians. Others studies have found that midwives are in an ideal position to undertake these examinations safely (Townsend *et al.*, 2004; Lumsden, 2005).

Ramsey and Paine (1997) discussed a development where midwives assisted at caesarean section and reported that this initiative was working very successfully. Read *et al.* (1998) undertook a survey of all labour ward staff in the same unit and concluded that, generally, the staff members were very positive about this extension of the midwives' role. In addition to these developments, midwives are also extending their skills to undertake ultrasound scans (Andrews, 2002). There is also evidence from Scandinavia of midwives successfully undertaking embryo transfer in assisted reproductive treatment (Bjuresten *et al.*, 2003). In some states in the USA certified nurse midwives (CNM) carry out the full range of family planning roles including taking cervical smears, prescribing contraceptives, and fitting intra-uterine contraceptive devices (IUCD) (Likis *et al.*, 2006).

MP posts, which comprise most of the aforementioned extensions to the midwives' role, have been a relatively new development in Wales. The first MPs were appointed

in Wales in 1998 and there has been little research into their impact on the midwifery carried out in the units in which they practise. This study aims to address this gap regarding the knowledge of extended roles in midwifery by exploring the role of MP, which was developed as a result of UK and Welsh health care policy recommendations, and its impact upon midwives and obstetricians in a maternity unit in Wales. The extended role of the midwife will be further considered in the literature review (see section 2.3).

1.4 Healthcare policy

Healthcare policy can be described as the decisions developed by government policy makers for establishing present and future objectives for healthcare services. This study was undertaken at a time of unprecedented change to the boundaries of the work of doctors and nurses/midwives, resulting from healthcare policy initiatives in the UK and Wales. Some of these changes resulted in nurses/midwives taking on technical work formerly done by doctors. In light of such changes to the scope of midwifery and nursing care, it is questionable whether midwives/nurses can embrace new tasks without the loss of the caring aspect of their role (Allen, 2001). This study will consider this issue by exploring the role of MP and its impact upon midwives and obstetricians in a maternity unit in Wales.

The disciplinary boundaries between healthcare professions have never been constant. Healthcare workers can change their professional boundaries adopting roles normally undertaken by others by encroachment upon others' areas of responsibility or by consensual delegation, where unwanted tasks are discarded to subordinate grades. Nancarrow and Borthwick (2005) describe the differing directions in which the healthcare workforce can change, these are: diversification, specialisation, and vertical and horizontal substitution. Diversification occurs when a new type of practice is developed, it is legitimized and owned by a professional group, by the regulation of the new technology and by the language used to describe it.

A specialist is defined in *Dorland's Medical Dictionary* as '*A physician whose practice is limited to a particular branch of medicine or surgery, especially one who,*

by virtue of advanced training, is certified by a specialty board as being qualified to so limit his practice' (1989: 550). In medicine specialisation provides increased financial rewards and prestige, however, this has not transferred to other specialist healthcare workers. It has been argued that specialisation relies on the ability of professional groups to delegate the more generic aspects of care to other providers. This can involve the creation of subordinate sub-groups, who undertake lower status work, which allows the profession to concentrate on the higher status aspects of care (Nancarrow and Borthwick, 2005). This can be seen in the increasing specialisation in obstetrics (RCOG, 2005), and the resultant development of nurse/midwife practitioner and maternity support worker (MSW) roles.

Vertical substitution involves the delegation of aspects of care between groups of differing status. The development of nurse/midwifery practitioner roles can be seen as an example of this. However, this differs from specialisation as it occurs across professional boundaries and rewards vary between differing groups, for example a nurse who prescribes does not receive the same rewards as a doctor. Vertical substitution is controlled by the most senior discipline. Horizontal substitution occurs when certain healthcare providers undertake roles normally carried out by another discipline, with similar levels of training and expertise (Nancarrow and Borthwick, 2005). This overlap of roles has been increased by multidisciplinary training and teamwork in the NHS. Such changes in the workforce present opportunities to replace expensive healthcare providers with groups who are cheaper to employ and have less power within healthcare. Healthcare policy in the UK and Wales actively encourages workforce flexibility, allowing groups to encroach upon traditional medical roles. The result of this is a reduction in the influence of the medical profession, while managers retain firmer control over new style healthcare workers, who do not have the levels of prestige or financial rewards bestowed upon the medical profession. This can be seen in the development of MP roles.

In recent years, UK healthcare policy has supported the provision of more generalist health workers, such as MPs and Nurse Practitioners who undertake aspects of the doctor's role, though it is as yet uncertain whether they will be allowed to practice autonomously without the constraints of medical control. However, if they prove to be effective and less expensive than doctors, it is likely that their position and numbers in

the provision of health care will increase. A similar situation is occurring in the United States, where it is anticipated that the number of non-physician clinicians will rise (McKinlay and Marceau, 2002). This study will explore the role of MP, which was developed as a result of UK and Welsh health care policy recommendations, and its impact upon midwives and obstetricians in a maternity unit in Wales. In doing so, this study addresses the gap in current knowledge about this new extension to the midwives' role. The effects of healthcare policy will be further considered in section 2.3.1 of the literature review.

1.5 Background to the MP role and research setting

This section provides some background information about the development of the MP role in the area where the research was undertaken. In addition, a brief summary background of the research setting – where Phases two and three were carried out – is outlined so that the study can be considered within its context.

The MPs in the research setting were appointed in 2003, following a successful bid to the Welsh Assembly Government (WAG) for funding from monies set aside to ensure compliance with *Junior Doctors: The New Deal* (NHSME, 1991). As WAG funded the MP role in Wales from *New Deal* monies, comparisons between the financial costs of MPs as opposed to SHOs cannot be made in this study. The first MP was appointed in October 2003, in the unit where phases two and three were undertaken, with two other posts following in July 2004. One of the MPs resigned in December 2004 and a new MP was instated in March 2005 (see Appendix 14). It was anticipated that the practitioners in these posts would act as a support and resource for midwives, nurses and medical staff, undertake assessment, diagnosis and treatment, attend high-risk births, deal with emergency situations and participate in doctors' ward rounds.

When the MPs were appointed, no clear criteria existed for the accepted competencies or training for these posts. An in-house induction programme was developed, in addition, junior doctors continued working "on-call" when the MPs were on duty, in case they needed assistance, and this situation continued for just over a year. This gradually built up MPs' confidence and competence to a point where they were happy

to work with only themselves and the middle grades on duty during the night. Besides their clinical responsibilities, MPs are also responsible for auditing, clinical teaching, and guideline and protocol development for the maternity and gynaecology departments.

Phases two and three of this study took place in the maternity unit of an NHS Trust in South Wales. This Trust was established in 1996 and serves a population of approximately 150,000, with an annual birth rate of approximately 1,500. The population is amongst the most severely deprived in Wales, it has some of the highest level of material deprivation, the lowest educational standards and the poorest quality housing in Wales (*Welsh Indices of Multiple Deprivation,* NAW, 2001). These factors adversely affect the health status of the population and place a high demand upon the Trust's health care services. Paradoxically, health promotion and disease prevention services are poorly accessed. Women from socially deprived areas are more likely to smoke, have poor diets, misuse drugs and alcohol and suffer from domestic abuse (Baggott, 2000; Waugh and Bonner, 2002). These factors can result in low birth weight babies and higher child mortality rates.

1.6 Key professional roles

The key roles discussed throughout this thesis are described to clarify their function. Each of these roles will be further explored as they are discussed in the text. Explanations of medical terms used throughout the text are also provided (see Appendix 1).

Midwife

The term 'midwife' is an Anglo-Saxon term which means 'with woman' (Donnison, 1988). Soranus was one of the most learned doctors of classical times; he was born in the first century AD in Ephesus, on the coast of Asia Minor. He studied medicine at Alexandria and practised in Rome. His most important work was *Gynecology*, the most complete account of the body of obstetric, gynaecology, midwifery and

paediatric knowledge, which was authored in the second century AD. Soranus' description of the role of the midwife in this work is still relevant today:

> The midwife should sit down opposite and below the labouring woman: for the extraction of the fetus must take place from a higher towards a lower plane... furthermore it is proper that the face of the gravida should be visible to the midwife who shall allay her anxiety, assuring her that there is nothing to fear and that delivery will be easy. (Soranus, translated by O. Temkin, 1956 in Dunn, 1995:F51)

In 1992 the International Confederation of Midwives (ICM), World Health Organization (WHO) and International Federation of Gynaecologists and Obstetricians (IFGO) accepted the following definition of 'midwife', which was updated in 2004:

> A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and childcare. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service. (Midwives Rules and Standards, Nursing and Midwifery Council, 2004:36)

Obstetrician

The introduction of male physicians into realms traditionally occupied by midwifery is said to have been traced back to the attendance of a male physician called Boucher on Louise De La Valliere, a mistress of Louis XIV in 1663 (Southern, 1998). Before the seventeenth century, no word existed for a male birth attendant; 'obstetrician' is a derivation of the Anglo-Saxon word describing a midwife which, as mentioned, means 'a woman who stands before' (Donnison, 1988). From the eighteenth century, doctors providing care during childbirth were calling themselves obstetricians (Masson, 1985).

Although the IFGO was involved in agreeing upon a definition of 'midwife', there is no officially recognised definition of 'obstetrician'. However, obstetrics and gynaecology together form a single medical speciality that provides reproductive health care, including care during the antenatal, intrapartum and postnatal periods (Llewellyn-Jones, 1999).

MP

MP posts were developed to carry out the role of junior obstetric doctors. MPs work directly with middle grade obstetricians and these posts generally cover both maternity and gynaecology services. MPs manage complicated cases and carry out aspects of care which were in the past predominantly performed by obstetricians (see Appendix 3 for details of work undertaken). As yet there is no official definition of the MP role, however, they differ from other senior clinical roles, such as Consultant Midwives and Senior Labour Ward Midwives.

Consultant Midwife

The concept of the nurse/midwife consultant was introduced by *The New NHS* (DoH, 1997) and *Making a Difference* (DoH, 1999a). These reports aimed to produce a health care worker who was a leader, a facilitator for clinical governance, a consultant, a researcher, and an educator. The recommendations of these reports aimed to develop a clinical career pathway and emphasised that Consultant Nurses/Midwives should maintain their clinical skills. There are five Consultant Midwives in Wales, whose remit concerns normalising childbirth and the work of Birth Centres (n=3) and dealing with public health issues (n=2). There are no Consultant Midwives in Wales who specialise in the medicalised aspects of maternity care.

Senior Labour Ward Midwife

These midwives are responsibe for the effective running of the labour ward, including ensuring all areas are adequately stocked, all necessary equipment is available and in working order, and that off-duty rotas are covered. While they provide advice and support for more junior midwives, when women develop complications they refer to

obstetricians or MPs. Unlike MPs they work in one specific area, rather than moving between wards and Departments.

1.7 Sources of data

A literature review is a process where the literature, either directly or indirectly related to the topic and proposed research, is critically reviewed. The aim of a literature review is to direct the researcher towards a relevant research strategy, which in this case is a focused ethnographic approach. A review of the literature also enables the researcher to establish how the research will fit within the existing knowledge of the subject to be studied and how it will make a unique contribution to this existing body of knowledge (DePoy and Gitlin, 1998). The documentary evidence examined for this thesis includes relevant books, journals, databases and policy documents. Topics relevant to the subject of the study were selected, and although the search period covered mainly the past 15 years, classic texts are also included. For this thesis, only papers available in the English language were reviewed. The papers that emerged from the review ranged from large randomised controlled trials (RCTs) to small-scale qualitative studies, though a high number of the studies reviewed were qualitative. The majority of the research papers reviewed were of a high standard (see section 2.1).

After consideration of the research aim, the following subject areas were selected as being relevant: regulation and the contemporary role of the midwife, autonomy and inter-professional relations, and the extension of traditional allied health professional, midwifery and nursing roles. Each of these themes is examined in the literature review chapter. Following an examination of the relevant literature a gap was identified concerning the extended role of the midwife in relation to the development of the MP role. As there has been no research into this new role, a qualitative, exploratory approach was the most suitable, while the use of ethnography allowed not only for the exploration of the MP role, but also for consideration of its impact upon midwives and obstetricians in the research setting.

1.8 Methodology

The methodological literature was reviewed in order to develop the study design. This qualitative study employs a focused ethnographic approach to study the culture of midwifery in a setting where midwives work as MPs. A qualitative approach fits with the purpose of the study, which is to reveal new understandings. A qualitative approach also fits with the researcher's preferred way of knowing, as it acknowledges the existence of multiple perceptions of reality. Ethnography is well suited as an approach for exploring complex clinical and organisational issues in health care, as it allows these subjects to be explored in a natural setting in context. In addition, ethnography allows complex professional relationships to be studied appropriately (Baillie, 1995; Savage, 2000). Ethnography is used in this study, as it is able to combine the perspectives of the researched and the researcher, and allow the researcher to explore the holistic nature of the research setting (Streubert and Carpenter, 1999). This study uses methods triangulation at the data collection level. Data were collected using three main different data collection methods and the findings from the different sources were compared to enhance the accuracy of the data interpretation.

By using observation, combined with interviews and focus groups, the investigator can see the participants' behaviour and hear their descriptions of their views and behaviour. One of the main advantages of using focus groups is the interactions between group members and the resultant insights, which would not be possible with one-to-one interviews or surveys (Morgan, 1997). Participant observation allows the researcher the opportunity to observe behaviour in the natural setting while participating in the context under scrutiny (Rees, 1997, DePoy and Gitlin, 1998). Semi-structured interviews are commonly used in qualitative research to explore perceptions, attitudes and experience, they use a series of open-ended questions about the subject of the study, but are flexible enough to allow sub-topics to develop (Harvey-Jordan and Long, 2001).

Ethical considerations

The research proposal, information sheets and consent forms (see Appendices 6 and 7) were submitted to the relevant ethics committees and ethical approval for the study was secured from the University of Glamorgan, School of Care Science Ethics Committee in 2002 and the Multi-Centre Research Ethics Committee for Wales in 2003. The relevant Local Research Ethics Committees were informed that the study had Multi-Centre Research Ethics Committee approval. This study was also registered with the relevant research and development committees of the Trusts where the research was carried out.

Pilot Study

A pilot study was completed for Phase one of the study, which involved undertaking two focus groups with eight student midwives from a university in Wales and a group of five midwives from an NHS Trust in South Wales. The aim of this was to improve the researcher's skills in moderating focus groups and to refine the topic guide. In Phase three a pilot study was undertaken with two midwives to test the interview schedule, ensuring that it was worded clearly, avoided bias and that the questions could be understood.

Data collection

The study was conducted in three Phases. Phase one was undertaken first in order to place the findings of the rest of the study in context, as previous research considered midwifery practice in England rather than Wales. It also provided information on midwifery at that specific time. In addition, it provided a basic understanding of how midwives perceive the role of MP. Phase Two was then undertaken in order to see and hear how MPs practice and how this role impacted upon midwives and obstetricians in the research setting. In Phase three I was able to explore these issues in more detail by asking clients, midwives and obstetricians about this subject and exploring further what I had seen and heard during Phases one and two. This allowed a clearer picture to be developed about this role and its impact upon the midwives and obstetricians working in the unit.

Phase one was conducted between May and August 2004 and involved the undertaking of focus groups (n=7) with groups of 5–10 midwives, who work in a variety of settings across four NHS Trusts in Mid and South Wales. In Phase two, participant observation was undertaken for approximately two weeks during November and December 2004 in a maternity unit in an urban setting, where three MPs are employed. Phase three was conducted from July to December 2006 and used in-depth, semi-structured interviews with a sample of obstetricians (n=7), midwives (n=10) and postnatal women (n=10). All interviewees were from the unit where Phase two of the study had been undertaken.

Data analysis

A strategy for the analysis of the data was developed based on the 'Framework' Method (Richie and Spencer, 1994). The transcripts and field notes were transcribed verbatim and imported into a computerised data analysis programe (NVivo), which was used to assist with text organisation and thus enable analysis. Analysis was undertaken concurrently with the collection of data. In ethnography, the gathering and interpretation of data cannot be separated, as ideas emerge during fieldwork and interpretations are often derived intuitively (Okely, 1994, DePoy and Gitlin, 1998). The findings from the three phases of this study were brought together and interpreted to uncover the meaning of the themes identified in the study.

1.9 Researcher's Reflexive Account

As a researcher my beliefs, history, values and interests affected almost all aspects of this research study, from initial choice of topic, to the methods selected, to how the fieldwork was conducted, through to interpretation and presentation of data. Therefore, it is imperative that this is included and acknowledged (Koch and Harrington, 1998). In accordance with the need for reflexivity in research I recount my experiences reflectively, outlining my background and motives for conducting this research and explaining my reasons for choosing this subject and methods, along with my initial views about the MP role.

I am a manager, clinician and novice researcher. During this study I tried to be constantly attuned to how my values and beliefs might impact upon my actions and interpretation of events observed or heard. I was also aware of the potential for an imbalance of power and endeavoured to avoid using my position in a negative way, which could exploit others. I see my role as a manager as being to empower, nurture and support midwives, in order for them to be able to empower, nurture and support the women for whom they provide care. I do not see my role as having power and control, but rather I am an enabler, I want to see autonomy in midwives not dependency. Though I have to admit that I have come to this view after a number of years in management and in the past I could have been described as autocratic and controlling. However, I have come to realise over the years that this approach is ineffective.

I have explored the newly established role of MP and its impact upon the midwives and obstetricians in the research setting. My original impetus for embarking upon this study was that I was involved in the establishment of the first midwifery led birth centre in Wales in the 1990s and was made acutely aware of the ability of obstetricians to resist changes that have the potential to undermine their control over maternity care. Since then I have been interested in new developments in midwifery. Also I am aware that not all of the changes, resulting from healthcare policy recommendations, that have impacted upon the midwifery profession, have been of benefit to midwives, nor indeed to clients, for example the recommendation for 100% hospital births from the Peel Committee (DHSS, 1970) and some of the recommendations of the *Changing Childbirth Report* (DoH, 1993), such as team midwifery.

The introduction of MP roles was yet another change, recommended by government health care policy, that was implemented without consideration of its impact. I felt there was a need to explore the new role and its impact upon midwives and obstetricians, in order to establish an evidence base for further extensions to the midwives' role and to identify any implications - positive or negative - of this new role. Although other studies have examined aspects of the extended role of the midwife, this is the first to explore the role of MP. In addition, I wanted to examine what midwives regard as the core, essential aspects of their role, in order to place the

study in context. Initially, I had concerns that MPs might enjoy the medicalised aspect of care (like a number of labour ward midwives - in the past I would have included myself in this group) and would not provide holistic – woman centred care.

As a researcher I am part of the research process and inevitably I made choices about which information to exclude and which I felt was important enough to include. I decided on the topic of the study and which research methodology to employ. However, I tried to be aware and open about my biases and motivations. Ethnography initially appealed to me because of my interest in anthropology (though my understanding of this was very superficial). I also thought it would be suitable to study MPs in their natural setting and to observe the ways in which they related to other health care providers and clients. I felt that ethnography would be a suitable research methodology as it would allow me to study holistically the culture of a maternity unit along with its complex occupational structures. It is also a suitable approach for studying intimate and practical activities, such as the provision of maternity care. Additionally, it allows for flexibility and adaptability when collecting data regarding participants' experiences and their interactions with others in the multidisciplinary team.

During this study I was somewhat reticent about the use of reflexivity and was acutely aware that it carried the risk of *navel gazing*, which might be indulgent and not helpful to the research process (Hertz, 1997; Koch and Harrington, 1998; Finlay, 2003). Notwithstanding this, it is acknowledged that self-disclosure is important as it provides the researcher with a means to make explicit the impact of their motives on themselves and others during the interpretative research process.

1.10 Structure of thesis

This section outlines the thesis, chapter by chapter. Chapter one presents an introduction to the subject of the thesis. An overview is provided of the history and development of the midwifery profession, healthcare policy relevant to maternity care is discussed and the development of MP roles outlined. Finally, the sources of data, methodology, reflexive account and the structure of the thesis are outlined.

Chapter two provides a literature review of the themes pertinent to the thesis. The first section is concerned with the role of the midwife. Secondly, extended traditional midwifery, nursing and allied health professional roles are considered. Finally, the issue of midwifery autonomy and inter-professional relations are discussed. The literature review identifies the lack of consideration previously given to the development of the midwives' role, it also points to a gap in the literature concerning the development of the MP role and provides guidance regarding the research method employed in this study.

Chapter three outlines the methodology used for this study. It discusses the rationale for the selection of the study design and describes the research methods, including their strengths and weaknesses and their appropriateness for this study. The ethical issues pertinent to this study are explored and the process of gaining Ethics Committee approval outlined. The process of conducting the research is described and the strategy for the interpretation of the data is examined. The effect of reflexivity during the research process is discussed and finally, the limitations of the method are considered.

Chapters four, five and six present the results of the study. The findings are presented in a narrative text with relevant quotes woven throughout to illuminate pertinent points. These chapters outline the findings from each phase of the study.

Chapter seven provides a discussion of the findings of the study and compares them with relevant literature, placing them within their context and identifying how the research aim has been addressed.

Chapter eight draws together the key issues raised in the study, in order to provide conclusions and recommendations about the MP role and its impact upon midwives and obstetricians in the unit where the research was undertaken.

CHAPTER TWO – LITERATURE REVIEW

Read not to contradict and confute, nor to believe and take for granted, nor to find talk and discourse, but to weigh and consider.
(Bacon, edited by Pitcher, 1985:209)

2.1 Introduction to the literature review

This chapter provides a review of the literature relating to the role of the midwife and the development of the MP role. The aim of a literature review is to provide an overview of the body of knowledge on a subject, to establish how the research will fit within the existing knowledge of the subject to be studied and how it will make a unique contribution to this existing body of knowledge. The literature review also directs the researcher towards a relevant research strategy (DePoy and Gitlin, 1998, Murray, 2002).

The literature review for this thesis was ongoing and evolving throughout the research process. An overview of the documentary evidence examined includes relevant books, journals, databases and policy documents. Use was made of the midwifery, nursing, sociological and medical literature, and was accessed by undertaking regular on-line computer searches of such databases as MEDLINE, the *Cumulative Index to Nursing and Allied Health Literature* (CINAHL), the *British Nursing Index*, the *Cochrane Library*, the *Applied Social Sciences Index and Abstracts* (ASSIA) and the *Midwifery Information and Resource Service* (MIDIRS). These databases comprise abstracts from international scientific journals, and key terms such as 'role of the midwife', 'autonomy', 'extended role of the midwife', 'inter-professional relations' and 'history of midwifery' were used.

Midwifery, nursing and medical journals were accessed, such as *Midwifery*, *Journal of Advanced Nursing* and the *British Medical Journal.* Journals related to the social sciences were also reviewed, such as *Journal of Sociology* and *Social Science and Medicine*. Policy and official documents relating to the role of the midwife were examined, and these were mainly DoH and WAG documents. In addition, relevant

references from material obtained were followed up. I also attended various conferences and spoke to key stakeholders (see Appendix 4 for examples of those consulted on aspects of the study and those who reviewed certain sections). The papers that emerged from the review ranged from large randomised controlled trials (RCTs) to small - scale qualitative studies, though a high number of the studies reviewed were qualitative. The majority of the research papers reviewed were of a high standard. I examined these papers initially by considering the design, the relevance to my study, where the studies were conducted and how their findings related to the findings of my study.

Prior to the regulation of the midwifery profession at the beginning of the twentieth century, midwives provided care for all women, regardless of risk and, to some extent, circumstances. With the advent of registration and supervision through the Midwives Act in 1902, restrictions were made to midwifery practice, which resulted in midwives being identified as responsible for assisting women in normal childbirth; the expressed requirement for them to call for medical assistance when abnormalities were detected was enforced. At that time and even today a number of midwives report a resultant dissatisfaction with their role and working lives (Kirkham, 1999; Ball *et al.*, 2002). However, recent changes to the scope of midwives' practice, resulting from *The Scope of Professional Practice* (UKCC, 1992) and the recommendations of various healthcare policy documents, have provided midwives with the opportunity to change and extend their work. This new freedom has resulted in some midwives expanding their role to provide care also for women experiencing complications during childbirth, such as those working as MPs.

Following a consideration of the research aim, the following subject areas were selected as being relevant: regulation and the contemporary role of the midwife, autonomy and inter-professional relations, and the extension of traditional allied health professional, midwifery and nursing roles. The section of the literature review concerning extended midwifery practice concentrates on developments to the midwives' role that increase midwives' decision-making and technical skills. The literature review does not include literature dealing with other ways in which midwives have extended their role – for example, midwives who work in the public health arena – as this is not relevant to the role of the MP. Each of the themes is

examined in this chapter. The literature reviewed covers mainly the last 15 years, though some other significant texts published before this time are reviewed; only articles in the English language are included. The review focuses on literature concerning healthcare services in the UK, but some papers from other countries are included, where relevant.

2.2 Regulation and the contemporary role of the midwife

Regulation of the midwifery profession in the UK resulted from the Midwives Act (1902). This section provides a review of the literature regarding midwifery regulation through to the contemporary role of the midwife.

2.2.1 Midwifery regulation

Prior to the seventeenth century, when men became involved in the provision of care during childbirth, midwives had been regarded as the group that undertook this work. However, from this time, the reputation of midwives was undermined and they were blamed, often unfairly, for unsafe standards. Midwives, who were female and generally from the working classes, found their position undermined by middle-class women who wanted to professionalise and regulate midwifery to provide themselves with respectable employment and by the medical profession who wanted to usurp their position (Hannam, 1994; Donnison, 1988; MacMillan, 2001; Mander and Reid, 2002) (see section 1.2 and Appendix 2).

The Trained Midwives Registration Society, led by Zepherina Veitch, eventually became the Midwives Institute, which was a forerunner to the RCM. Its membership comprised middle-class, unpaid women, whose stated aims were to improve conditions for working class women during childbirth and to raise the status of midwives. To this end, they made arrangements with the medical profession, agreeing to limit midwives' autonomy and scope of practice and allowing doctors to assume the dominant position in the provision of maternity care. The eventual result of this was the Midwives Act (1902) (Donnison, 1988; Hannam, 1994; MacMillan, 2001; Mander and Reid, 2002).

Turner (1902) discusses how proposals to legislate midwifery began in 1813, but that the Midwives Bill was not introduced until 1900. Supporters of the Bill pointed out the high maternal and infant mortality rates when midwives were untrained and there were many heated debates in the House of Parliament. Sir John Williams highlighted the fact that 'The maternal mortality rate was 1 in 200 when midwives were untrained and 1 in 1000 when they were trained' (Turner, 1902:627). Mr. Rathbone, Member of Parliament, a supporter of the Bill, highlighted some of the issues that had delayed it:

> Year after year the Midwives Bill had failed to pass. It had been sacrificed, sometimes to the claims of Government upon private members' time, sometimes to the jealousy of the least enlightened members of the medical profession, more often to the indifference, the apathy, and the ignorance of the House of Commons about a Bill, which they did not take the trouble to understand.... (Rathbone, 1900:35)

Ridgway (2002) describes a survey of doctors' views of the Bill, carried out by the *Lancet* at this time, which showed that only 21% of the total respondents (n=7,187) supported the Bill. There were a number of reasons for this, but it was generally felt that it would put midwifery on par with medicine and reduce the status of doctors. This view was also expressed by the General Medical Council, which wanted to have control over midwifery practice but this responsibility was ultimately given to the Privy Council. To satisfy the medical profession, the Bill had to be explicit that midwives would be separate from the Medical Act and would neither have the same autonomy as medical men, nor practise on the same level as doctors. The Bill licensed midwives to practise normal midwifery and ensured that they should be able to recognise deviations from that norm and call for medical assistance. After much debate, the third reading of the Midwives Bill took place in the House of Commons in June 1902. It was then sent to the House of Lords, where after further delay caused by the acceptance of the Obstetrical Society's Certificate for midwifery practice, the ninth Bill was passed on the 20th June 1902 (Ridgway, 2002).

Stevens (2002) describes how the Midwives Act (1902) was the first legal recognition and regulation of midwives in this country. The Act was not passed by Parliament until 1905 and the statutory provision of training did not start until the later Midwives Act of 1918. The stated purpose of the Act was to improve training and regulation in the midwifery profession, and prohibit uncertified midwives from practising. The

Central Midwives Board (CMB) was established in 1902 and was comprised predominantly of doctors, the first midwife not being appointed as chairperson until 1973. The CMB was responsible for setting up examinations and making rules regarding the supervision, regulation and the restriction of midwifery practice and it had the power to remove midwives' names from the roll. However, it also helped ensure the medical profession's increased dominance over maternity care.

Duff (2002) contends that it is internationally acknowledged that the strong regulation of midwifery has brought benefits for both midwives and childbearing women, as it has ensured the provision of safe maternity care. In Sweden during the 1800s, as a result of a national policy favouring professional midwifery care for all births and the introduction of standards for quality care, there was a marked reduction in maternal mortality. Maternal mortality in Sweden was the lowest in Europe at the beginning of the twentieth century. Other European countries followed suit, as did Japan. In contrast, the United States focused on delivery by doctors in hospital settings and its maternal mortality figures stayed high. However, Alves-Diniz (1973) argues that laws rigidly delimit the function of midwives by restricting their responsibilities. Midwifery legislation should ensure the maximum contribution of midwives during the time of childbirth. However, regulation should not encourage midwives to be inflexible in their practice and should allow for the extension of their role, so that they may contribute to improvements in maternity care (Duff, 2002).

The Midwives Act (1902) set up a system for supervising midwives, where 'lady superintendents' worked in the interests of the medical profession and the state to police midwifery practice. The term 'lady superintendent' was changed to 'Supervisor of Midwives' in 1937, when the role was redefined to include being a friend and counsellor to midwives, as well as ensuring public protection. This resulted in confusion and conflicting roles for supervisors. Supervisors had the power to inspect midwives by observing them during their work, questioning their clients and even by visiting their homes to ensure that all equipment and drugs were stored correctly. Even today, if a complaint is made against a midwife, the supervisor can investigate and refer her/him to the Local Supervising Authority, who can suspend her/him from practice.

O'Connor (2001a) points out that the system of supervision of midwives in operation in the UK is unique, and some midwives feel that it should be replaced with a different system to ensure safe standards within the midwifery profession. O'Connor (2001a:165) comments that it is incredible that 'women volunteer... to supervise the work of other women on behalf of the state'. Supervisors of Midwives appear to collude with obstetricians to control midwifery practice, this alliance with the oppressor could be considered in light of the characteristics of oppression described by Kuokkanen and Leino-Kilpi (2000) and Romyn (2000). It seems that while midwifery practice continues to be so closely controlled and monitored by Supervisors of Midwives, it is unlikely that midwives will gain the confidence and freedom necessary to become autonomous practitioners and provide a midwifery model of care.

From 1902 to the establishment of the NHS in 1948, most midwives worked in the community and in 1927, 85% of all UK births took place at home (Walker, 1954). Therefore, most midwives managed their own caseloads, practised away from the constraints and controls of the hospital setting and were subject only to an annual review from their Supervisor of Midwives (Hunter, 1999a; 1999b). The CMB remained the regulatory body for the midwifery profession until 1983. The Briggs Committee (DoH, 1972) recommended the establishment of a single regulatory body for nursing, midwifery and health visiting. At the time, the CMB tried to argue that midwifery was a profession separate from nursing and should have its own regulatory body (Symon, 1996). However, in spite of this the United Kingdom Central Council (UKCC) for Nurses, Midwives and Health Visitors took over from the CMB and confirmed the association between midwifery and nursing (Thomas, 2002).

In April 2002, the Nursing and Midwifery Council (NMC) took over from the UKCC as the new regulatory body for nurses and midwives. This is the current regulatory body for nurses and midwives in the UK and has responsibility for setting the standards for training, education, conduct and performance and for making arrangements to ensure these standards are met (Lewis, 2002). However, nurses outnumber midwives by two to one in this organisation (O'Connor, 2001b). The combined regulation of nursing and midwifery has resulted in combined education and management structures. Until recently, most midwives had to train as nurses

before going on to undertake midwifery training, and midwives continue to be managed by Directors of Nursing within NHS Trusts. O'Connor (2002) contends that as midwives are recognised in European law as autonomous practitioners, a legal framework should be developed to enable midwifery to develop structures separate from nursing for its regulation, management and education and with legal rights to prescribe certain medicines and regimes.

Thomas (2002) discusses the successes of the midwifery profession over the last 20 years. These include the move of midwifery education into higher education institutions from the mid 1900s (late 1980s in Wales) and the establishment in 1992 of a programme for the preparation of Supervisors of Midwives. However, there is no consideration in this paper of the challenges faced by the midwifery profession during this period, such as the increasing medicalisation of childbirth and the concomitant effect on midwives.

As would be expected the papers concerning midwifery regulation are predominantly descriptive and tend to have been written by midwives and those who support their point of view. It is therefore unsurprising that, an examination of the literature concerning the history of midwifery during the last century provides examples of how the practice of predominantly female, working class midwives has been restricted and controlled by the recommendations of healthcare policy which appears to have supported obstetricians to the detriment of midwives. Even regulation, which for the medical profession has been a source of professional power, left midwives in a weakened position. Furthermore, the supervision of midwives continues to ensure that midwifery practice is closely monitored and controlled, leaving midwives with little autonomy.

2.2.2 Midwifery functions and responsibilities

Currently, a midwife in the UK can be described as an individual who holds a midwifery qualification and who is registered on the NMC's register of nurses and midwives (NMC, 2004). A midwife can work in a variety of locations, such as a hospital or in the community, may provide all maternity care for women at low

obstetric risk or work with obstetricians and other health care workers to provide care for women at high obstetric risk.

Bryar (1995) identifies two approaches to providing maternity care, each at opposite ends of a continuum. The first approach is often described as the medical model of care, while the second is often perceived as being the midwifery model of care. With the first approach, childbirth is defined as a potentially pathological process requiring intervention, in order to ensure a live and healthy mother and baby. At the other end of the continuum, childbirth is considered a natural process and each pregnancy is seen as a unique event. The midwifery model of care stresses the need for women and their families to be involved in decision-making and choices regarding the type of care they receive. This approach also aims to ensure a live and healthy mother and baby, but the satisfaction of individual needs is also seen as an important outcome.

> The dominant biomedical model is viewed by many as inherently disempowering. It is a hierarchical model, which sees the woman as a patient from whom compliance may reasonably be expected. The midwifery model of care, in contrast, views the woman as a client whose relationship with her midwife is one of a 'negotiated partnership'. (O'Connor, 2002:160)

Although the biomedical model of care has resulted in reductions in maternal and infant mortality rates, there is also evidence to suggest that other factors have played a role, such as improved nutrition and housing (Illich, 1976; Cahill, 2001).

Bryar (1995) suggests that an individual midwife's approach to care can be placed at some particular point on the continuum, between these two models of care. Many commentators suggest that the medical and midwifery models of care are in opposition (Davis-Floyd, 1992; Campbell and Porter, 1997); however, Annandale and Clark (1996, 1997) contend that the discourses of midwifery and medicine are related. A study by Foley and Faircloth (2003), undertaken in the United States, uses interviews with direct-entry midwives (n=26) to examine their work narratives, and confirms the argument of Annandale and Clark (1996, 1997).

Robertson (2002) contends that the impact of the medical model of care upon maternity services has resulted in midwives becoming de-skilled, which has led to

many midwives becoming obstetric nurses who watch over technical equipment and carry out the instructions of medical staff. She goes on to argue that it is not just medical interventions that disturb the natural process of labour, but also social interventions such as requiring births to take place in hospital and limiting the number of chosen birth companions.

Robertson (2002) suggests that the role of the midwife is to understand the birth process and support the woman throughout it, ensuring her needs are met and that the process remains undisturbed unless a complication is identified. However, the medical model of care impinges upon the autonomy of midwives, restricting their ability to ensure that women have autonomy over the type of care they receive. O'Connor (2002) argues that there needs to be a balance between the medical and midwifery models in maternity care and that both should take into consideration the service users' perspective.

Nicholls and Webb (2006) undertook a systematic review of 33 papers dating from 1993, which used a variety of approaches and methods, in order to establish what constitutes a 'good midwife'. The review found that it is one who is skilled at communication, kind and supportive, able to treat women as individuals and involve partners in the process of childbirth possessing knowledge and skills appropriate to their occupation. It was also deemed necessary that midwives be involved in education and research.

The requirements for pre-registration midwifery programmes (UKCC, 2000) consider this matter in more detail and outline the 29 competencies that a midwife requires to practise effectively and safely, without the need for direct supervision. These competencies were grouped under six principles (see Box One), which together describe the skills and abilities that an educational programme leading to entry of part 10 of the NMC register must teach – though they do not specifically outline the necessity for safe practice and the maintenance of health.

Box One: Principles of midwifery practice

Demonstrate a woman-centred approach to care based on partnership, which respects the individuality of the woman and her family.

Promote ethical and non-discriminatory practices.

Reflect the quality dimension of care through the setting and maintenance of appropriate standards.

Develop the concept of lifelong learning in students, encompassing key skills including communications and teamwork.

Take account of the changing nature and context of midwifery practice.

Base practice on the best available evidence.
UKCC (2000:3–4)

The following studies attempt to define the responsibilities and functions of midwives. Fullerton *et al.* (2003) undertook a study for the ICM to set out the skills, knowledge and behaviours that characterise the domain of competencies of a midwife who has been educated according to the international definition of 'midwife' (see 1.6). A stratified random sample of midwives were recruited from 65 countries over four continents. A qualitative Delphi study was undertaken during Phase one, and for Phase two a descriptive survey research process was employed. A list of 214 individual task statements was developed and grouped within six domains of midwifery practice (see Box Two).

There were some limitations to this ambitious study. The sample from countries with larger memberships to the ICM is not statistically representative and can only be described as reflective. In two countries, the sample was not random, but comprised a convenience sample that was drawn from the midwives who were accessible to the researchers. The main limitation, however, was the language barriers: there was no opportunity to ensure that the translations of survey answers were precise in terms of their English-language meanings. Although this was a large and comprehensive study, as a consequence of these limitations its findings may not appropriately represent the views of midwives from the countries included in the study, which may have resulted in the competencies being somewhat non-

specific. Interestingly this study does not conclude that the midwife needs any knowledge from the biosciences.

Box Two: List of competencies for competent midwifery practice

Competency 1 – Midwives have the requisite knowledge and skills from the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for women, newborns and childbearing families.

Competency 2 – Midwives provide high quality, culturally sensitive health education and services to all in the community in order to promote healthy family life, planned pregnancies and positive parenting.

Competency 3 – Midwives provide high quality antenatal care to maximize health during pregnancy and that includes early detection and treatment or referral of selected complications.

Competency 4 – Midwives provide high quality, culturally sensitive care during labour, conduct a clean and safe delivery, and handle selected emergency situations to maximize the health of women and their newborns.

Competency 5 – Midwives provide comprehensive, high quality, culturally sensitive postnatal care for women.

Competency 6 – Midwives provide high quality, comprehensive care for the essentially healthy infant from birth to two months of age.
Fullerton *et al.*, (2003:174–190)

A study by Pope *et al.* (1997) investigated the role and responsibilities of midwives, in an effort to determine their continuing educational needs. This study was commissioned by the English National Board for Nursing, Midwifery and Health Visiting and was the first of a series of six papers that present the key findings from a national study and provide an overview of midwifery functions. Postal questionnaires were sent out to the following: a national stratified random sample of NHS midwives (n=1,100) (response rate 70%), all coordinating supervisors in England (n=205, response rate 83%) and consultant obstetricians (n=205, 46% response rate), all from each maternity unit in England, a national random sample of general practitioners (n=250, response rate 65%). Following the postal questionnaires, case studies involving semi-structured interviews were undertaken in three sites across England with medical staff and midwives of varying backgrounds (n=90). In addition, clients

(n=115) and representatives from six national professional and statutory organisations were interviewed.

The results presented by Pope *et al.* (1997) from this comprehensive study relate mainly to the background of the practising midwives and the care they provide. The midwives were predominantly E, F and G grades (see Appendix 1) and the length of time from qualification was from two months to 36 years. Seventy percent of the midwives reported providing the following aspects of care: recognising the need to call for medical assistance, record-keeping, giving advice, providing intrapartum care, examining and caring for the newborn, undertaking emergency care in the absence of doctors, monitoring normal pregnancy and providing postnatal care. These activities fit within the *Midwife's Code of Practice* (UKCC, 1994), but there appeared to be some ambiguity, as some of the midwives felt that they were practising autonomously and providing full care during the antenatal period, even when medical staff were also involved in the provision of care during this time. It is difficult to argue that midwives are autonomous practitioners when the first aspect of midwifery care discussed by midwives in this study was calling for medical assistance. As could be anticipated, variations in practice were noted among midwives who differed in terms of grade, contracted hours and area of practice.

Hyde and Roche-Reid (2004) undertook a study to understand how midwives perceive their own role. A sample of midwives (n=12) with experience in working in labour ward settings, was recruited from three maternity hospitals in the Republic of Ireland. In-depth interviews were carried out using a semi-structured interview schedule regarding midwives' perception of their role and their views on the active management of labour, along with the influences over their role and the degree of autonomy they felt they had. This study concluded that the midwifery model of care was limited by the constraints of working within an environment where the medical model of care dominated and client passivity was accepted as the norm.

The literature concerning this subject suggests that the role and responsibilities of the midwife are complex, diverse and difficult to define. However, it might be argued that as long as midwives base their practice on normality, they are likely to continue to be placed in a weak position in the provision of maternity care. Defining the concept of

normality is problematic, as the boundaries between what is considered 'normal' and 'abnormal' are subject to change, and can result in difficulties in defining and categorising the normality upon which midwives base their care (Murphy-Lawless, 1998; Taylor, 2001). In addition, the ease with which obstetricians are able to clearly define abnormality has allowed the medicalisation of childbirth to increase (Gould, 2000).

2.2.3 Conflicting philosophies of care

The issue of conflicting philosophies of care was highlighted by Hunter (2004), who carried out a study to explore how midwives experience emotion in their work. This qualitative study employed an ethnographic approach and was undertaken in three phases using focus groups, observation and interviews. During phase one, a convenience sample of student midwives (n=27) attended four focus groups. In phase two, midwives (n=11) attended two focus groups. In phase three, midwives (n=29) attended four focus groups; in addition to this, midwives (n=12) were interviewed and observed during the course of their normal clinical practice.

This insightful study identifies conflicting ideologies among midwives in community settings who had a woman-centred ideology, and those in the hospital setting who had an ideology based on meeting service needs. This resulted in emotional conflicts that were more prevalent in midwives working in integrated teams that covered both hospital and community settings, and in newly qualified midwives. The main source of dissatisfaction in midwifery practice originated with these conflicting ideologies. By addressing this conflict, midwives could improve both their experience of practising as a midwife and the care they provide for women. The sample size in this study was smaller than planned and comprised mainly E and F-grade midwives (see Appendix 1); therefore, the views of more experienced midwives remain unknown. This subject was also explored in an additional paper by Hunter (2005), which originated from this study.

Lindberg *et al.* (2005) investigated the pressures felt by midwives when they are not able to provide the sort of midwifery care they believe best meets women's needs.

This study describes midwives' experience *vis-à-vis* changes in the organisation of services and their caring role and function in postnatal wards. It was carried out in the northern part of Sweden, where during the previous five years, three of the eight maternity units had closed and the length of the typical hospital stay had been reduced. These changes are similar to those experienced by midwives in the UK.

For Lindberg *et al.*'s study, focus groups (n=4) were undertaken with midwives (n=21) who had experience in maternity units, the groups took place in two hospitals. The study found that the midwives felt loss and grief for their old practice, but still wanted to develop their future role. This resulted in midwives trying to give the same amount of care as they had prior to the changes, but in a shorter period of time. Some midwives felt that this resulted in them having to provide a type of midwifery care that ran counter to their beliefs. The midwives' sense of loss over the old system of providing care may have resulted from the way the change was managed. It appears the midwives felt that they had had no control over the changes and did not know what was expected of them, as they had not received support in altering their practice in light of the changes. This situation was similar to the changes in the maternity services in the 1990s in the UK. In terms of this literature review, the limitation of this study is that it was undertaken in Sweden, where the system of postnatal care differs from the system in the UK. For this reason, comparisons between study findings in Sweden and findings in the UK should not be made without careful consideration. However, the Swedish study effectively exposes the difficulties faced by midwives when the type of care they want to provide differs from what is achievable in the maternity service in which they practice.

The concept of conflicting philosophies has also been discussed in a number of other papers. McIntosh (2003) describes the conflict of being expected as a student midwife to ask questions and discover answers, while being expected as a qualified midwife to 'do as you are told'. She stated that her preconceived philosophy of midwifery was one that revolved around the woman and her family, but the philosophy, which appeared to be followed in the hospital setting, was one of being 'busy' dealing with technology and meeting service needs. Davis-Floyd (2005) contends that the biomedical hegemony over both the midwifery profession and the childbearing process has left midwives with burdensome workloads, but relatively little autonomy.

Thus, midwives often find themselves working under stress as they struggle to balance conflicting knowledge systems and ideologies. Warriner (2003) comments that within maternity services, many midwives find themselves trying to find a compromise between a woman's needs and the needs and constraints of the service. In this sense, they have to find a compromise between the institutional philosophy and their own personal philosophy.

2.2.4 Dissatisfaction with midwifery practice

The studies reviewed in this section are qualitative and are of a high standard. It is apparent from the literature that providing maternity care for women is stressful for midwives. In addition to the pressures of having to balance the individual needs of women and the overall needs of the service, they must also deal with women's pain and urgency during the birth process. They also have to cope with partners and other relatives who, in their attempts to support women, place additional demands on the midwife. Although midwives possess the expertise for ensuring, whenever possible, a safe outcome for both the mother and baby, concerns about failing to provide safe care can result in blame, guilt, and worry over possible litigation. Symon (2006) states that concerns over increasing rates of litigation are unfounded, as there is no evidence to support this view however, it is acknowledged that these concerns – justified and otherwise – have the potential to adversely affect midwives and increase the levels of stress experienced.

When all of these issues are considered, it is unsurprising that some of the midwives in the various studies have come to perceive their work roles as stressful. Menzies (1960) studied the defence mechanisms employed by nurses to deal with the emotional stresses of their work, and these mechanisms can also be observed in the midwifery profession. These are: splitting the relationship between carer and patient by fragmenting care, so that building emotional relationships with women becomes difficult as responsibility for care is divided among a number of different professionals; avoiding emotional involvement through the provision of task-oriented care, thus employing a production-line approach and rigidly following policies and procedures rather than providing individualised care and; avoidance of autonomy and

responsibility for decision-making, which occurs when any case with complications is referred to medical colleagues. These behaviours were noted to be accompanied by other tactics, such as denial and avoidance of change.

Great caution must be exercised when trying to gain any understanding of the current situation by extrapolating from the Menzies study which was undertaken in 1960 and looked at nursing in the 1950s, when task allocation was the norm.

A more recent and thus more useful ethnographic study was undertaken by Kirkham (1999) to examine the culture of midwifery in England and gain insights into how midwives view their world. This influential study forms a part of a larger study into the supervision of midwives. The research was carried out in five sites, and in-depth semi-structured interviews were undertaken with midwives (n=168) of various grades and from different practice settings. Midwives felt that the system took advantage of the fact that they wanted to provide the best care for women which was becoming increasingly difficult for midwives as a result of lack of support and resources. Midwives also perceived a pressure to conform to a system that they themselves did not embrace. The midwives described feelings of guilt and stress because they could not meet the expectations of the service. The study concluded that midwives practice in a culture where they lack the rights, as women, that they are expected to enforce for their clients, namely choice and control.

> Midwives who are expected to facilitate choice and control for clients often lack professional experience of such facilitation, exercise little choice and control in their work and mistrust management. (Kirkham, 1999:737)

The dilemma of attempting to balance the pressures of providing woman-centred care, while meeting the needs of the maternity services, appears to be a cause of stress and dissatisfaction for midwives. This issue was also considered by Lavender (2004), who explores the views of midwives about the then current systems of maternity care across England. Although other studies have considered this subject area, this was the first to give an overview of the commonality and diversity of midwives' views across the country. This study used an appreciative inquiry approach and employed focus groups (n=15) to gather data in variety of sites (n=14) across England. A purposive sampling strategy was employed, where midwives from various clinical settings and

experience were recruited (n=126). This study supported the findings of Kirkham (1999), in that there were problems with the culture of midwifery in England.

Lavender (2004) found that some midwives felt that they worked in a maternity unit (n=6) that supported a midwifery model of care, though in a larger number of maternity units (n=8) a medical model of care was adhered to, and it was felt by the midwives that this was supported more by senior midwives than by obstetricians. Midwives reported more job satisfaction and higher morale in units where there was a midwifery model of care and a desire to provide all aspects of care for low-risk cases. It is questionable why the medical model of care continues to dominate, if (as is reported) the majority of midwives want it to change. The alternatives as to why this should be so are equally unappealing. Either midwives lack the will to make changes or they do not have the autonomy and power to resist the pressure of the dominant medical profession. Elston, (1991), Larkin, (1993) and Thorne, (2002) contend that the medical model remains in the ascendant in maternity units in the UK.

The study by Lavender (2004) notes that negative responses regarding the experiences of midwives were more prevalent in consultant-led units, whereas a more supportive environment was noted in free-standing midwifery-led units. The midwives made suggestions that there should be a rotation between midwifery-led and obstetric units, but a study by Ball *et al.* (2002) finds that such a rotation between clinical areas was perceived as a negative factor (see below). Dissatisfaction with midwifery practice may have contributed to recruitment and retention difficulties in midwifery services. The RCM has gathered information regarding rates of midwifery vacancies since 1996 for their *Evidence to the Pay Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine.* In 2003, it reported the highest long-term midwifery vacancy rates to date; it also reported that 77.3% of Heads of Midwifery felt that the funded midwifery establishments in their maternity units were inadequate (RCM, 2003).

Ball *et al.* (2002) undertook a notable study entitled *Why Do Midwives Leave?* to obtain a clear picture of the reasons midwives, who had recently left the midwifery profession, gave for leaving. The sample comprised all midwives who notified the UKCC of their intention to practise in 1999, but who did not practise in 2000

(n=2,325). The study was conducted in two phases. In phase one, a random sample of midwifery 'leavers' (n=250) were sent a postal survey, this was followed by ethnographic interviews with 28 of these midwives. In phase two, a questionnaire developed from information gathered during phase one was piloted with midwives (n=100) and was subsequently forwarded to the remaining midwives (n=1,975). In total, there was a 52% response rate (n=1,016).

The findings from phase one reported that midwives found the process of making the decision to leave both protracted and painful. Reasons for persisting in the desire to leave included clinical grading and restructuring of management, both of which led to a change in ethos and atmosphere in the work environment. These adverse changes were made worse by the increasing demands of the job. In phase two, five main reasons were given for leaving: 'dissatisfaction with midwifery' (29.9%), 'family commitments' (17.6%), 'planned career change' (11.3%), 'retirement' (10.4%) and 'ill health' (10.2%).

The main reason for the dissatisfaction reported with midwifery practice was the inability to practise the type of midwifery required in the NHS, this finding is in line with those of Hunter (2004). This concern was more evident in younger, newly qualified midwives, and there appeared to be a disconnection between the type of midwifery practice for which their education prepared them, and the reality of practising in the NHS. The issue of having to rotate through all areas of clinical practice and through all shift patterns was also an issue for midwives, as they had difficulty in maintaining both their expertise and their relationships with colleagues and clients. Lack of support and communication from managers was also cited as a reason behind midwife dissatisfaction but the report acknowledged that midwifery managers themselves had little freedom to change the situation.

A further study was carried out by Curtis *et al.* (2006) to address the findings of the study by Ball *et al.* (2002) with reference to midwifery managers and explore their views about the difficulties *vis-à-vis* the recruitment and retention of midwives. A qualitative research study was undertaken and data were collected from focus groups (n=8) and individual interviews (n=4). This study found that managers experienced a lack of autonomy and were powerless to make the necessary changes to improve

midwives' practice situations, most tellingly, they felt that they were expected to 'reconcile irreconcilable service demands' (Curtis *et al.*, 2006:100). There was a consensus that inadequate midwifery establishments compounded staff shortages, and the view was expressed that managers often have to supply services, thus providing client care at the margins of safety. Issues that had reportedly worsened the situation were related to the higher levels of client dependency, which had in turn resulted from the increasing medicalisation of childbirth. However, the main cause was said to have resulted from needing to provide woman-centred care without the necessary resources.

Policy documents such as *The Changing Childbirth Report* (DoH, 1993a) have recommended changes in midwifery practice that are positive for women, but which for midwives have resulted in expectations of an unrealistic level of commitment. In addition, changes were made quickly, in some cases without the midwives' support, and were under funded (see section 1.2). This occurred at a time when steps were being taken to improve the working lives of medical staff by reducing the working hours of junior doctors (NHSE, 2003). It also appears that the medical profession has successfully maintained its power over the provision of maternity care during this time (Elston, 1991; Larkin, 1993; Thorne, 2002). This has left midwives working in environments that restrict and control their practice, making it difficult for them to provide a midwifery model of care and practise autonomously.

2.3 Autonomy and inter-professional relations

This section considers the literature concerning the autonomy of midwives and inter-professional relations in order to examine the level of autonomy in midwifery and nursing practice in the UK.

2.3.1 Midwifery autonomy

An autonomous practitioner is defined by Marshall (2005:12) as a professional who is 'free from both controlling interference from others and from limitations... that can

affect making meaningful choices and decisions'. While Keenan (1999:561), in attempting to establish an operational definition of autonomy, defines it as 'the exercise of considered, independent judgment to effect a desirable outcome', this definition does not encompass the issue of acting without constraint which is addressed by Gillon (1995:60) who describes autonomy as 'the capacity to think, decide, and act on the basis of such thought and decision freely and independently and without hindrance'. This is of relevance to the midwifery profession, whose autonomy has been to a certain extent determined and curtailed by both medical practitioners within maternity care and by those who have influenced the regulation of the midwifery profession. Moreover, as Siddiqui (1996) points out, during the last century, the majority of midwives originally trained as nurses, and they had been socialised to accept a role where compliance with the requests of doctors was regarded as the norm.

Nixon and Power (2007) state that changes to the formal educational programmes to prepare occupational groups can be highly significant in the quest for autonomy and professional status. The professionalisation of midwifery has been the driver for moving midwifery education into universities and educating midwives to degree level. Marshall (2005) argues that the move of midwifery education to universities and the establishment of direct-entry midwifery degree courses have produced midwives who are better able to act as autonomous practitioners. However, newly qualified midwives are under pressure to conform to the culture in which they work, if they are to 'fit in' and become accepted (McIntosh, 2003; Warriner, 2003; Davis-Floyd, 2005).

A study by Currie (1999) investigates certain aspects of the preparation of student midwives for autonomous practice and looks specifically at the relationship between student and mentor. This is a small qualitative, grounded theory study that used in-depth interviews for data collection. The sample comprised student midwives (n=7), mentors (n=7) and night duty midwives (n=4). This study found that there was conflict between trying to provide autonomous, woman-centred care, while working within the constrained culture of a hospital setting. It was noted that the students appeared to be fearful of independent action and demonstrated non-assertive practices, passive learning and compliance. The study concluded that midwives

needed to be aware not only of the factors that affect their ability to work as autonomous practitioners, but also the impact of these on midwifery practice.

This issue was also addressed by Bosanquet (2002), who discusses how midwifery practice within the hospital setting controls the behaviour of midwives. This ensures compliance with the dominant medical culture, rather than encouraging midwives to be autonomous practitioners who provide holistic, woman-centred care. She argues that midwives' knowledge and skills in supporting women through the process of normal birth are marginalised by the power of obstetrics and its emphasis on the use of technology and the medicalisation of childbirth. Student and newly qualified midwives most often work in hospitals and experience a process of 'organisational socialisation' that ensures that they become assimilated into the culture, absorb the values and accept the hierarchy of the hospital setting. This often involves conflict between newly qualified and more experienced midwives who have already been through the socialisation process. New midwives find that they either 'fit in' or develop coping strategies, which eventually lead to burnout, stress, low morale and absenteeism. Midwives who are unable to become assimilated are likely to leave the profession (Begley, 1999 and 2001).

Pollard (2003) carried out a study to gain insight into midwives' understanding of the term 'autonomy' and whether they consider themselves and other colleagues to be autonomous practitioners. In this qualitative study data were collected from semi-structured interviews, which were organised using a thematic content analysis. The sample included midwives (n=27) working in five NHS Trusts in Southwest England, comprising both hospital and community staff. There appeared to be a lack of understanding by participants regarding the implications of professional autonomy and disagreement about whether they and their colleagues practised autonomously. Many did not feel that their education prepared them for practising in this manner; some felt that the goal of autonomous practice was unrealistic, whereas others felt that many midwives did not support other midwives' – or indeed their own – professional autonomy. The findings of this study indicate that more research is needed into how midwives can practice autonomously, as the present situation is not benefiting either midwives or users of the service.

A quantitative study undertaken by Kenny and Adamson (1992), using interviews with allied health professionals (n=90), found that the majority of participants (73%) did not feel they were perceived as being equal to doctors nor that doctors understood their role. In spite of this, 74% felt that they had adequate autonomy, but also commented that this autonomy 'allowed' them to offer doctors advice and discuss their instructions with them, thus indicating their lack of awareness of autonomy. Only 49% felt able to form relationships and socialise with doctors. This study also found that the more experienced health care workers felt they had more autonomy than did the more junior staff members. This may have been the result of them accepting their position within the hierarchy of the health service.

Lewis (1998) contends that if midwives want to be regarded as autonomous professionals, there is a need for them to demonstrate that they are prepared to accept accountability for decision-making:

> If midwives want greater freedom to practise, they must be willing to assume greater responsibility, accept their accountability and develop decision-making skills. This will ultimately give them the power and position to truly care for women and control their own destiny as a profession. (Lewis, 1998:60)

However, following a number of changes in healthcare policy, the medical profession appears to be losing some of its power over the provision of health care. This may provide midwives with the opportunity to improve their position but this will only be achieved if they are prepared to accept the need for increased responsibility and, subsequently, autonomy. Symon (1996) suggests that midwifery calls itself a 'profession' – not so much as an accurate way of describing itself, but more as wish fulfilment; he states that '*a tendency to pass the buck and withdraw from a position of accepting responsibility is not compatible with calling oneself a professional*' (Symon, 1996:547). Bradshaw and Bradshaw (1997) assert that midwifery cannot be described as a profession in its own right – at least not while obstetricians still retain control over midwifery practice.

2.3.2 Inter-professional relations

During the last century nurses and midwives strived to improve their professional status and their level of influence in their relationship with doctors. Towards the later part of the twentieth century a number of factors affected the medical profession, which have in turn accelerated these changes. These include globalisation, increasing use of the Internet, diminishing lack of trust and respect for doctors and increased demands for collaboration and communication (Kennedy, 1981; Giddens, 1990; Beck, 1992; Kennedy, 2001; McKinlay and Marceau, 2002; Smith, 2004; RCOP, 2005). In addition, recommendations of UK health policy documents such as, *Making a Difference* (DoH, 1999a) and *Realising the Potential* (NAW, 1999) call for traditional health care boundaries to be altered to meet current health care needs. This requires collaboration and partnership working but studies reviewed in this section found that, generally, the relationship between medical staff and nurses/midwives remains somewhat problematic.

If collaborative working is to be successful, nurses (and midwives) need to develop strategies for ensuring that their voices are heard when care is planned, to make sure all aspects of patients' conditions and needs are identified and acted upon. Carmel (2006) undertook an ethnographic study, employing observation and interviews in three Intensive Care Units (ITUs) to consider the relationship between nurses and doctors. He found that in an ITU setting the relationship between nurses and doctors is informal and demonstrates mutual respect, which is in contrast to other studies (Combs and Steven, 2004; Manias and Street, 2001a). Carmel argued that the occupational boundary between nurses and doctors is obscured in ITU settings, while the boundary between the ITU and the rest of the hospital is reinforced. It seems that the closer collaboration between these occupational groups increases the influence of critical care teams without posing a threat to doctors' autonomy.

Manias and Street (2001a) undertook a study to describe how critical care nurses participate in ward rounds and they explored the power relations between nurses and doctors. The study used a critical ethnographic approach and data were collected using participant observation and professional journaling, along with individual and focus group interviewing. A purposive sample, comprising six registered nurses of

various grades, was recruited from one critical care centre in Australia. In contrast to the above study, Manias and Street found that the doctors dominated interactions during ward rounds. The nurses resented this, but they were unable to affect changes to the system, as consultants effectively used processes to maintain control. The information provided by nurses was seen as supplementary and not integral to care planning. It was felt that the format of the ward round should be altered to ensure more collaborative communication, which would benefit patient care, as all aspects of their condition would then be considered and addressed. The limitation of this study is that it was conducted in only one area with a specific type of ward round. Also it did not include the medical perspective. Although this research cannot be generalised to other settings it does provide information to identify and challenge such practices when they occur in the workplace.

An ethnographic study by Combs and Steven (2004) examines control over decision-making in the clinical arena of ITUs, where there are traditionally close nurse-doctor working relationships, in order to examine the nurses' role in clinical decision-making. Participant observation was undertaken over a six-month period in three intensive care units. This study demonstrates that doctors and nurses have different roles and value different types of knowledge. The researchers found that medical staff primarily held the knowledge base used for decision-making, and that this had persisted in spite of policy drivers towards multi-disciplinary working. It appears that nurses are able to see the limitations in the knowledge of attending physicians, but do not challenge this, thereby maintaining and reinforcing the belief in the supremacy of medical knowledge. Both professional groups saw the nurses' role in decision-making as being there to 'chip in' with supplementary information, rather than having a central part to play. The findings illustrate that nurses lack the confidence to challenge doctors who thus found it easy to ignore their concerns. Although it can be seen as appropriate for doctors to make clinical decisions regarding patient care, by disregarding the knowledge of the nursing staff, information that could have influenced and improved the decision-making process may be missed. Despite the fact that doctors stated that they understood the importance of nursing knowledge, it seems that doctors continue to retain authority over decision-making, as demonstrated in a number of other studies (Bushby and Gilchrist, 1992; McCallin, 2001; Blue and Fitzgerald, 2002).

Although midwives and nurses have always played a role in assisting doctors in decision-making this is usually done in a submissive way. Stein (1967) calls this process the 'doctor-nurse game' and describes it as the way in which nurses make recommendations to doctors, and doctors request advice from nurses, without disturbing the power dynamic between the two occupational groups. The aim is for the nurse not to appear to be making recommendations and the doctor not to appear to be requesting advice. If the game is to be played successfully, the following must take place:

> The nurse is to be bold, have initiative, and be responsible for making significant recommendations, while at the same time she must appear passive. This must be done in such a manner so as to make her recommendations appear to be initiated by the physician. Both parties must be acutely sensitive to each other's nonverbal and cryptic verbal communications. (Stein, 1967:699)

If the game is played well it can meet the needs of both groups. In any case it stifles open and direct communication, reinforces the nurse's submissive and inferior role and confirms the authority of the doctor in the hierarchy of health care provision. The 'game' supports the stereotypical roles of the male-dominated medical profession and the female-dominated nursing profession. However, Stein *et al.* (1990) state that the 'doctor-nurse game' is changing, as nurses and doctors have begun to communicate more openly.

This view was shared by Hughes (1988) in an influential study based in a casualty department of a DGH in the UK, where participant observation was undertaken over a ten-month period. This study demonstrated how nurses no longer have to employ the doctor-nurse game, as there are a number of circumstances in which nurses' influence has been strengthened. This study also found that in dealing with patient categorisation and triage, nurses were becoming involved in diagnosis and treatment, blurring the boundaries between the activities of nurses and doctors. However nurses only rarely gave direct instructions to doctors and this only occurred with junior medical staff. Generally, the nurses in this study did not see themselves as making the diagnosis, as they merely provided doctors with information and cues that indicated what the diagnosis was. This assistance was again more common when dealing with junior or transient medical staff. This type of action is somewhat subversive and

avoids taking responsibility, which could imply that these nurses were still employing aspects of the doctor-nurse game.

Following on from this Svensson (1996) carried out a study, using semi-structured interviews (n=45), into the interplay between nurses and doctors in medical and surgical wards in five Swedish hospitals. He argues that rather than being characterised by the dominance of the medical profession (Freidson, 1970) and the doctor-nurse game described by Stein (1967), the social order seen on wards can be seen as a negotiated order, which provides opportunities for nurses to exert power within the ward environment. Despite this, not everything in the hospital setting is subject to negotiation, with manipulation and coercion often being used to make people behave in certain ways. Svensson argues that the relationship between nurses and doctors has changed radically over recent times, and has been influenced by team nursing which has increased nurses' holistic knowledge of patients and increased recently qualified nurses' contact with medical staff. However, this study also found that nurses avoided openly challenging medical opinions, which may imply that the doctor-nurse game has not been completely eradicated. Also when nurses tried refusing to comply with unreasonable requests e.g. giving medications without written prescriptions, they often gave in if patient care was likely to be detrimentally affected.

Allen (1997) further explored Svensson's theory of the interplay between nurses and doctors being a 'negotiated order.' Data were gathered from participant observation and semi-focused interviews with nurses (n=57), on a medical and surgical ward of a DGH in the UK. Allen makes an additional contribution to Svensson's concept, by considering features of hospital work, which hinder nurse-doctor negotiations, but which nonetheless, impact on the division of labour. During the interviews there were differing perspectives about the changing boundaries between the work of nurses and doctors, with examples provided of contested boundaries. However, during the observation such disagreement and uncertainty were not noted. The nurses expressed the view that they would only carry out doctors' work if it did not impact upon nursing care, but in practice they did this in spite of its effect on the other work they had to complete. Allen suggested this discrepancy demonstrated their need to feel in control of their work boundaries.

This study also found that the permanence of nurses and the transience of doctors on wards increased nurses' knowledge of patients and systems, which in turn increased their influence and power over clinical care and the education of doctors. As doctors have to cover more than one ward, their priority is finding the most efficient way of completing their work, while nurses see their central role as ensuring patient care is provided on schedule. To achieve this they endeavor to organise the work of doctors. Attempts by lower status workers to influence the work of higher status workers can often result in conflict and friction in the workplace. The problems nurses encountered in getting doctors to come to the ward to carry out medical tasks, often resulted in nurses routinely completing such work themselves, acting outside their jurisdiction. This was done to ensure appropriate patient care, resulting in the non-negotiated blurring of the boundaries between nursing and medical care. Although this increased nurses' autonomy and avoided friction and conflict, it also put the nurses at risk. This study demonstrates that the organisation of hospital work results in non-negotiated boundary blurring becoming an accepted element of nursing practice. However, it might have identified different perspectives if data from doctors as well as nurses had been considered.

The nurse-doctor boundary was considered further by Allen (2000), using additional data from the above study. The ways in which senior medical staff negotiated changes to the nurse-doctor boundary were investigated and it appeared that they were happy about technical tasks being delegated, but they had reservations about the delegation of activities they regarded as central to their role, such as making a diagnosis. Nurse managers tried to ensure they retained control over the process of devolved aspects of the medical role by developing comprehensive education packages, which often resulted in nurses having to demonstrate their competencies in complex ways, which medical staff viewed as unnecessary. Senior doctors were keen to recast nurses as subordinate workers who undertook basic technical tasks previously the domain of doctors, but senior nurses saw the aim of extending the nurses' role as being to improve holistic care rather than to ease the burden of doctors. These differing viewpoints reflect the attempts of both groups to construct a view of the changing boundaries in line with their individual occupational identities. Although the changes in the boundaries between nursing and medicine were being negotiated and contested at a senior level, such conflict was not noted in ward areas, as discussed above.

The ambivalence about the blurring of professional boundaries between nurses and doctors was also noted by Barton (2006b) who undertook an ethnographic study to explore the experience of medical mentors who provide clinical mentoring for Nurse Practitioners (NPs) undertaking a BSc degree course. This study found that doctors' experience of mentoring NPs was generally positive. However, it was also noted that this role resulted in conflicting views about of supporting a role, which challenged medical authority and produced a re-negotiation of professional boundaries.

Snelgrove and Hughes (2000) carried out a study into the inter-professional relations between nurses and doctors, which considered whether things had changed in relation to the use of the doctor-nurse game (Stein, 1967). The study was carried out on medical wards of a DGH in South Wales. Data were collected from semi-structured interviews with nurses (n=39) and doctors (n=20). The study found that there was a degree of blurring of professional boundaries, mainly resulting from work pressures and specialised practices in certain areas. Nurses stated that they challenged doctors' decisions in order to ensure patient advocacy, however, they appeared reluctant to openly challenge doctors' decisions and often framed their questioning in ways that avoided confrontation. Nurses viewed increased education as being the route to role expansion, while doctors valued experience and felt that this would enable nurses to expand their role. Generally, doctors were happy to delegate tasks to nurses, but were more reticent about delegating the decision-making and diagnosis aspects of their role, as identified by Allen (2000). They did, however, acknowledge that NPs were an exception to this rule and accepted that they had responsibility for assessment and diagnosis. In general, this study suggested that nurses and doctors continued to view their roles in traditional terms, but acknowledged that some changes were occurring in nurse-doctor relations.

Allen (2001) undertook a research study to examine occupational boundary-work in a hospital setting, drawing on the insights of discourse and conversation analysis, focusing on the stories told by nurses about doctors. Data were collected on the medical and surgical wards of a DGH in England, over a ten-month period, using participant observation and interviews. The nurses' stories demonstrated a high level of consensus and were told primarily to other nurses and were never recounted in front of doctors. This type of storytelling served to constitute membership of the

nursing group. Almost all of the stories concerned doctors and were predominantly negative towards them, citing their inadequacies in relation to their communication skills, clinical competence, and their disregard for hospital protocols. These stories also concerned the limits of nursing jurisdiction. Nurses portrayed themselves as often having more expertise than doctors, but acknowledged that they should have more confidence in their clinical skills and judgment. The stories demonstrated that doctors, as transient workers on the wards, were not seen as being part of the ward team, while this is also the case for student nurses they did not feature in the stories, perhaps because unlike doctors they did not exercise any control or power over the nurses or care provision and so were not in conflict with them.

It appears that generally the nurse-doctor relationship is an uneasy one, where nurses struggle to influence and to be seen as equal partners in the provision of care. The exceptions to this occur in specialised departments which appear to be somewhat insular, having their own identities and ways of providing patient care, such as ITUs. In these cases it appears that the sense of belonging to the department takes priority over professional identities. Although maternity units could be described as specialised and insular, communication and interaction between doctors and midwives there can be problematic. Brownlee *et al.* (1996) carried out a study into aspects of inter-professional interaction and communication, as perceived by midwives (n=20) and obstetricians (n=15) in the labour ward of a large regional tertiary maternity unit in Scotland. The midwives felt that communication between themselves and obstetricians was good but the obstetricians expressed some concerns. They stated that midwives' autonomy could be problematic and that their role was ill defined. They also noted that midwives did not trust junior medical staff, which can be explained by the mismatch between their skills and their place in the hierarchy. Both groups of professionals felt that midwives were better able to build a rapport and communicate with women than were doctors. Medical staff also commented that midwives sometimes made reference to 'covering their backs' and were reluctant to take responsibility. This was also noted by Dyas and Burr (2003), who comment that midwives regularly write the words, 'doctor-informed' in women's case notes as a way of offloading responsibility onto obstetricians. This reluctance to accept responsibility may result from the accumulative effects of the recommendations of health care policy upon professional roles.

2.4 Extension of traditional allied health professional, midwifery and nursing roles

The Scope of Professional Practice (UKCC, 1992) and the recommendations of UK health policy documents have suggested opportunities for midwives to develop and extend their role. This subject is discussed in this section, to examine the benefits and issues related to extending the midwives' role (see section 1.3).

2.4.1 Healthcare policy context

A number of healthcare policy documents have influenced the establishment and development of the MP role and are discussed in this section in order to put this new role in context. MP posts were developed to meet the gap in service provision left by the reduction in junior hospital doctors' working hours. At the same time policy documents relating to the field of nursing and midwifery care were recommending the expansion of the nurses' and midwives' roles. It seems fortuitous that factors affecting medical staffing provided timely opportunities for nurses and midwives to extend their roles.

Healthcare policy affecting midwifery and nursing

The Scope of Professional Practice (UKCC, 1992a) allowed nurses and midwives to develop and extend their role by stating that nurses and midwives could cross professional barriers to improve care, resulting in midwives being able to extend their role to undertake duties that had previously been carried out by doctors. Although midwifery managers should give appropriate assistance in order for midwives to make suitable adjustments to their practice, midwives have to acknowledge their limitations with regards to knowledge and ability declining to undertake tasks which could put patients at risk (UKCC, 1992b). However, as long as midwives have received training and have the required skills to carry out the required tasks, there are no legislative limits to the activities they can perform (Dimond, 1999).

Midwifery: Delivering Our Future (DoH, 1998), proposed that midwives should develop their role in different ways, with some midwives providing midwifery-led care for low-risk women, and others developing technical expertise to care for women at high obstetric risk alongside obstetricians. Documents such as, *Making a Difference* (DoH, 1999) and *Realising the Potential* (NAW, 1999) opened the debate on innovations in practice, calling for collaboration and partnership working between doctors and midwives, in order to alter traditional health care boundaries to meet changing health care needs. The result has been the development of existing pathways and the creation of new career pathways for nurses and midwives.

More recently *Modernising Nursing Careers: Setting the Direction* (DoH, 2006), was published, which forms part of the DoH's overarching strategy to modernise the NHS workforce and has links with the DoH Modernising Healthcare Careers Board. It sets out to describe nursing within the changing context of healthcare and identifies four priority areas or actions required to deliver a nursing workforce that is fit for the modern NHS and is sustainable into the future.

The four priority areas are to:

- Develop a competent and flexible nursing workforce.
- Update career pathways and career choices.
- Prepare nurses to lead in a changed healthcare system.
- Modernise the image of nursing and nursing careers.

As part of the first priority – 'developing a competent and flexible workforce,' there was a review of career paths and educational preparation for specialist and advanced roles. This resulted in the production of an advanced practice toolkit, which covers such things as titles, competencies, academic preparation and career frameworks in line with KSF and A4C (DoH, 1999c; DoH, 2004), (see Appendix one). In addition, as MPs and NPs work beyond the initial registration level it is hoped the NMC's *Consultation on a Framework for the Standard of Post-Registration Nursing* (NMC, 2005) will help address their educational needs (though this was only circulated for consultation in England). Currently the Modernising Midwifery Careers Project - *Midwifery 2020* (DoH, 2008) is focusing specifically on the midwives' role in a

similar way in which *Modernising Nursing Careers: Setting the Direction* (DoH, 2006) did for nursing.

In Wales NLIAH (National Leadership and Innovation Agency for Healthcare) produced the *Standards and Guidance for Role Redesign in the NHS in Wales* (2007), which specifically sets out the process for planning and developing new healthcare roles. In Ireland, *The Framework for the Establishment of ANP and AMP posts* (National Council for the Professional Development of Nursing and Midwifery, 2004) provides similar guidance specifically for nursing and midwifery posts. Also in Ireland Begley *et al.* (2007) describe the development of an MSc course at Trinity College, Dublin to prepare Ireland's first AMPs. However, it is unclear what specific duties these AMPs will carry out, as such posts can be developed in a number of different ways.

The loosening of the restrictions upon nursing and midwifery practice can be perceived as a positive development. However, until recently health care policy recommendations have encouraged the development and extension of nursing and midwifery roles, without clear guidance on how such developments should be planned (DoH, 1993a). Current policy documents are now addressing this issue (NLIAH, 2007, DoH, 2008), but there is still no indication of how such developments can be taken forward within existing staffing establishments, nor are there any recommendations to increase the training places for nurses and midwives. This may result in unmanageable workloads and a proliferation of staff retention problems.

There is generally a great deal of work ongoing regarding the development of the nurse/midwife role and the MP role is just one way in which midwives are developing to utilise all their skills and cross professional boundaries in order to provide effective holistic woman-centred care.

Healthcare policy affecting medical staff

In addition to the effects of nurse/midwife policy documents, healthcare policy affecting medical staff has also influenced the development of NP and MP roles. *Junior Doctors: The New Deal* (NHSME, 1991), and *The Working Time Regulations*

(NHSME, 2003), aimed to improve the working lives of junior doctors, while ensuring the quality of patient care by reducing errors resulting from fatigue. *Junior Doctors: The New Deal* (NHSME, 1991) was implemented in a staged process which ensured that junior doctors' working hours were reduced by 1996, so that they did not have to work more than 72 hours a week or 56 hours working with the rest of the time on call (Read *et al.*, 1998). The costs of non-compliant posts was made prohibitively costly for NHS Trusts by the junior doctors contract of 2000, but compliance with New Deal regulation only became a contractual obligation in August 2003. Therefore at this time NHS Trusts had to find ways of reducing junior doctors' hours, one of the ways in which this was done in maternity services was the development of MP posts.

European member states accepted the EWTD in 1996; however, its acceptance was delayed in the UK as the government appealed to the European Court of Justice to have it annulled, as it was felt that it was too costly and difficult to implement. The appeal was unsuccessful and the Working Time Directive was introduced in the UK in 1998. The Working Time Regulation was implemented in the National Health Service in 1998 (NHS Executive, 1998), though a number of health service workers were excluded. In August 2004 the key provisions of the *Working Time Regulations* (NHSE, 2003) were amended to include doctors in training. The requirements of this were more stringent than New Deal. By August 2004 there had to be an average of a 58 hour maximum working week, with EWTD rest requirements built in; by August 2007 this had to be reduced to an average of a 56 hour maximum working week and by August 2009 there will have had to be a reduction to an average 48 hour maximum working week. It has been estimated that if the recommendations of the *Working Time Regulations* (NHSE, 2003) are to be complied with, the UK will need at least 12,000 more doctors, which is unrealistic, both in terms of costs and availability of new recruits into medicine (MacDonald, 2004).

Junior Doctors: The New Deal (NHSME, 1991), and *The Working Time Regulations* (NHSME, 2003) have resulted in opportunities for midwives and nurses to extend and develop their role to work as MPs and NPs. A study by Cass *et al.* (2003) found that the introduction of new nursing roles has had no adverse effects on patient care or job satisfaction for staff, while being effective in reducing junior doctors' hours. However, it has been argued that the reduction of junior doctors' working hours,

which resulted in the introduction of shift working, has not met its aim of improving working conditions for junior doctors and may have negative implications for patient care (MacDonald, 2004; Akerman, 2005; Ahmed-Little, 2007). There is also evidence that shift patterns involving long stretches of night duty can have an adverse effect on health and performance (Knauth, 1995; Knauth, 1996). Conversely, Dowling *et al.*, (1995) undertook a six-month exploratory case study project, which found that if new nursing roles were free from unnecessary restrictions and used to their full potential, then patients would benefit from improvements in care provision. Though, for this to be achieved, there is a need for strategic issues, such as educational needs, role specification and prescribing rights, to be addressed. It has also been argued that new roles can raise levels of confusion over accountability. However, risks can be reduced through close partnership working between nurses/midwives and doctors in the planning, training and management arrangements for these roles (Dowling *et al.*, 1996). This issue was also explored by McKenna *et al.* (2006) (see section 2.3.1). The recommendations of these health care policy documents were imposed upon the medical profession, who had no option but to relinquish aspects of their role. The differing views about this issue may demonstrate uncertainty and unease about these changes.

Other healthcare policy documents, which impacted upon medical staffing included *Hospital Doctors: Training for the Future* (DoH, 1993b). This aimed to improve specialist hospital training and recommended that the length of specialist training should be seven years and that Registrar and Senior Registrar Grades should be merged into a Specialist Registrar Training Grade. It also advised that more explicit and detailed training programmes should be developed and that a certificate of completion of specialist training should be introduced and registered with the GMC. *Unfinished Business* (DoH, 2003a) analysed the problems with the Senior House Officer grade, and aimed to reform this role. At the same time *Modernising Medical Careers* (DoH, 2003b) took the view that whenever possible patients should be treated not by doctors in training, but by appropriately trained doctors. The suggestions in the report aimed to avoid Senior House Officers becoming delayed in this grade, while awaiting specialist-training opportunities. One way to achieve faster progress for junior doctors is to develop training programmes that allow doctors to become consultants approximately seven years after graduation, (previously 10-12

years). These policies were more acceptable to the medical profession as they not only aimed to improve doctors' training, but the solution to the problem was seen to be achievable by means of an expansion in the number of consultants.

An additional factor affecting medical staffing is that obstetricians are likely to continue to specialise in different aspects of obstetrics, which may result in a reduction in the number of generalist obstetricians (Coburn and Willis, 2000; RCOG, 2005). Obstetric consultants will almost certainly work as generalists, specialists or sub-specialists, but the way of achieving this is seen by the RCOG as being by means of an expansion of consultant posts rather than MP posts, due to the concomitant implications for midwife recruitment and retention (RCOG, 2005). In addition, the RCOG has also called for an increase in the amount of consultant labour ward cover, which would necessitate more consultant posts (RCOG, 2007). It seems that health policy recommendations will ensure adequate consultants for the proposed expansion of this grade. However, as obstetric consultants will be unable to undertake all obstetric care themselves, it may also provide opportunities for more MP posts, as this would avoid patients being treated by doctors in training. Although, the cost of such an expansion in consultant posts would be extremely high, the medical profession has generally been very successful in protecting and promoting its own interests (see section 1.2).

Although health care policy has provided opportunities for the development of NP and MP roles, existing systems and infrastructures have not yet been changed and developed to support them. An example of this is nurse prescribing, which has not yet been sufficiently developed to enable MPs to reach their full potential.

Nurse Prescribing

As a number of systems have been developed to allow nurses to prescribe, this remains a somewhat confusing issue for both clinicians and NHS Trusts. The introduction of prescribing rights for nurses has been regarded by some with scepticism. It has been seen as a cost cutting exercise that allowed doctors to delegate tasks that they did not want to undertake (McHale, 2002) and there has been concern over accountability. However, *Extending Independent Nurse Prescribing Within the*

NHS in England: A Guide for Implementation (DoH, 2002b) states that if a nurse is acting appropriately while carrying out her professional duties, then her/his employer will be held vicariously liable for her/his actions. It also states that nurses should ensure they have professional indemnity insurance.

The Cumberlege Report (1986) proposed the idea that nurses should be allowed to prescribe a limited number of drugs. Following this *The Report of the Advisory Committee on Nurse Prescribing* (DoH, 1989) recommended that nurses, qualified to work in the community, should be able to prescribe from a limited formulary of medicines. This was not extended to hospital - based nurses, as they had easy access to medical staff, therefore this is unsuitable for MPs and results in limited opportunities for nurses to prescribe as it required the completion of a specific training course. It also necessitated doctors and nurses drawing up local protocols for drug administration which led to concerns over the limited scope for nurses and disquiet over their legal position.

The 1998 Crown Review (DoH, 1998a) recommended the use of 'patient specific directives.' These have similar restrictions for MPs as a doctor has to make a diagnosis and write a clinical management plan outlining the drugs to be administered before the NP or MP can administer the medicines. Each condition must have a separate plan and written consent from patients must be obtained. Although this is suitable for NPs working in a GP practice, it is of limited use in acute care (Glynn, 2006). *The 1998 Crown Review* (DoH, 1998a) clarified the legal position of 'patient group directives.' These are used when individual patient diagnosis and prescription are not necessary. However, they are not suitable for MPs working in an acute care setting, as the prescribing nurse or midwife has to administer the drug herself.

Supplementary prescribing was introduced following *The Proposals for Supplementary Prescribing by Nurses and Pharmacists and Proposed Amendments to the Prescription Only Medicines (Human Use) Order 1997* (DoH, 2002c). It is used for patients whose conditions have already been diagnosed by medical staff and who have management plans drawn up (Cook, 2002). Unfortunately this does not cover the drugs and conditions, which MPs would encounter although there are legal mechanisms that would enable its use by midwives. This system tends to be time

consuming and cannot be used by MPs who assess and make management plans without doctors being present.

Some ANNPs currently use existing regulations to prescribe, but surveys have found that there are variations in the number of ANNPs who undertake this aspect of care. Redshaw and Harris (1999) found that 64% of respondents were prescribing, while Smith and Hall (2003) found that only 50% of respondents prescribed. This may result from variations in the types of roles undertaken by ANNPs, but may also indicate general difficulties with current regulations concerning nurse prescribing. The 1999 Crown Review (DoH, 1999b) introduced independent prescribing, where nurses assess patients, make-decisions about management plans and prescribe medication. However, only limited numbers of controlled drugs can be prescribed and there are restrictions upon the types of clinical conditions to which this applies.

In recent years the recommendations of health policy documents provide opportunities for midwives to extend their role in new ways, carrying out duties traditionally undertaken by doctors and working as MPs. In addition, it appears that healthcare policy is beginning to ensure that appropriate planning and necessary educational programmes are developed for advanced nursing and midwifery roles. However, systems, such as those for nurse prescribing and referral to other specialities have not yet been sufficiently developed to allow NPs and MPs providing acute care to work in a completely unrestricted way, though some aspects of independent prescribing may be of use to MPs. These restrictions may limit MPs to junior positions within the medical hierarchy. Despite the medical profession taking steps to ensure any changes to health care provision will be reliant on more consultant posts, such changes may also be accompanied by an expansion of NP and MP roles. Although this may inadvertently benefit the nursing and midwifery professions, there is a need to ensure that any changes are accompanied by an appropriate increase in their staffing levels.

2.4.2 Extended allied health professional roles

In addition to the factors influencing midwives and nurses to extend their practice, Allied Health Professionals (AHPs) also face similar drivers to further develop their role. *The Framework for Role Development in the Allied Health Professions* (The Scottish Government, 2005), outlines the need for AHPs to have clear career development plans, more specialisation and skill development and for the role of support workers to be explored. It recommends that changes should focus on improving services, comply with regulatory requirements, be underpinned by education, training and management support, build upon existing skills and expertise, complement the work of others in clinical teams, be competence based and protocol driven and meet the needs of patients.

Collins *et al.*, (2000) carried out a study of AHPs (n=162) and nurses (n=452) undertaking new innovative roles. A questionnaire was completed by respondents to ascertain their views about career development, job satisfaction, intention to leave the profession and factors that hindered or enhanced effective working. The study concluded that though the majority of participants felt their work provided them with job satisfaction, it was essential that the boundaries of their roles were well defined and that they received appropriate support. It was also felt that professional integration and career progression were important factors in ensuring job satisfaction.

McPherson *et al.*, (2004) undertook a systematic review of 355 papers, for the 'National Co-ordinating Centre for NHS Service Delivery and Organisation R&D,' in order to synthesize the evidence concerning the extended role of AHPs. This review found that although a number of extended practices, traditionally carried out by doctors, had been undertaken by AHPs, the resulting impact of these changes has rarely been evaluated. It also found that there was little evidence regarding how new roles can best be introduced, or how such workers can most successfully be supported and educated. The literature concerning this subject indicates the need for further examination and evaluation of extended AHP roles.

2.4.3 Extended midwifery practice

Dimond (2000) proposes that if midwives are to expand their scope of practice, it may be necessary for them to delegate tasks they currently perform, to either nurses or maternity support workers (MSWs). She goes on to state that some tasks, other than attending to a woman during childbirth, can be delegated. However, the standard of care cannot be lowered and midwives will have to interpret the results of tests and observations and supervise care provided by others. The RCM (2005) states that the introduction of staff such as MSWs in maternity services should be within a framework that defines their responsibilities and the arrangements for their supervision. Bradshaw and Bradshaw (1997) contend that midwives view the extension of their role to undertake tasks delegated by obstetricians as an opportunity for upward occupational mobility – an opportunity that would allow them to hand over the less skilled aspects of their role to MSWs.

A study by Woodward *et al.* (2004) was undertaken in England to explore the views of Heads of Midwifery (n=25), Lead Midwifery Educators (n=30), Local Supervising Authority Officers (n=3), user representatives (n=3) and one business manager, concerning the role of MSWs. Data were collected using interviews and a postal survey. The study found that MSW roles were developed in response to shortages of midwives and a desire to support midwives in improving services. It was acknowledged that these roles have become necessary as a result of the changes to the scope of midwifery practice and the professional status of the midwifery profession. Although MSWs work under the direction and supervision of midwives (RCM, 1999), a number of respondents felt that MSWs should be regulated in a manner similar to nurses and midwives.

Sandal *et al.* (2007) undertook a large-scale survey into the role of MSWs in England, in order to provide a systematic overview of their numbers, training, scope and range of practice, service models and skill mix. A hundred percent (n=10) of the primary care Trusts and 63% (n=98) of acute Trusts in England were sampled, with a 40% and 70% response rate respectively (n=73 NHS Trusts), resulting in information being gathered from 94 maternity units. Data were collected using a structured questionnaire, which was sent to Heads of Midwifery, prior to completion by

telephone. The study found that managers expressed enthusiasm about the contribution these roles made to the maternity team. Examples of this contribution included: improving continuity of carer, one to one care in labour, attendance at home births, breastfeeding support and assisting in obstetric theatres. However, the study found considerable variation in the titles, grades, range of activities undertaken and required entry levels of training. A need was identified to develop a national framework for competencies and training, and for appropriate governance arrangements to be established. Though this study provides valuable information, data were gathered from managers, rather than from direct observation of practice, which may have had an effect upon the findings.

Kaufman (1999) describes the findings of three RCM surveys regarding MSWs. The first and third surveys found that an increase in the number of these posts would allow midwives to concentrate on the core aspects of their role and spend more time with women, and respondents were generally supportive of further expansion of the MSW role. However, the second survey highlighted concerns that midwives would not be happy with a further extension of these roles. This was confirmed by McKenna *et al.* (2002), who found that midwives did not want to lose contact with the mothers in their charge and were unhappy about delegating tasks to others. Concerns have been expressed that MSW posts may encroach upon the role of the midwife and reduce standards of care (Francomb, 1997; Kaufman, 2001). Nevertheless, it seems that an increase in these posts is likely, and the RCM is now offering membership to MSWs – which might have the advantage of increasing the overall membership, but does not fit easily with the exclusive nature of a profession (Skewes, 2006). However, if the midwives' role is to extend and develop further without a significant increase in midwifery staffing levels, the need for more MSW posts will be unavoidable. Further research in this area might point to a need for the midwifery profession to take a proactive role in the development of MSW posts.

The RCM (2002) stressed the importance of establishing a clear understanding of the midwives' role, to ensure consistency of standards of maternity care and to maintain a defined body of midwifery knowledge. Dimond (1999) points out there is no legislative limit to the activities midwives are able to perform, so long as they have received appropriate training and have the skills needed to carry out the procedure.

However, the dominance of obstetricians over the provision of maternity care and the restrictive effects of regulation have, in the past, curtailed any radical extension of the midwives' role. Warwick (2000) argues that it is a waste of resources for midwives to duplicate care provision by asking obstetricians to check their work and by deferring to junior doctors who may have less knowledge and experience; she also proposes that normality could be re-defined to increase the type and number of activities that midwives could undertake. Symon (1996) contends that the midwifery profession has an opportunity to bolster its autonomy and claim professional status by providing midwifery-led care and extending its role in providing care currently undertaken only by obstetricians. McGuire (2003) discusses the importance of midwives giving each other professional recognition, but states that for this to be achieved, midwives need to acknowledge their professional responsibility and take an active role in clinical decision-making.

Fawdry (1994) argues that the complexity of the childbirth process makes the division of childbearing women into 'normal' and 'abnormal' difficult to achieve. He also argues that while midwives continue to provide care only to women with no complications, and to hand over responsibility to obstetricians as soon as any abnormalities are detected, they cannot expect to be treated as autonomous practitioners. He also illustrates the way in which some doctors viewed midwives, by way of an extract from a humorous column first published in May 1994 in the *BMA News Review*; it describes how a fictitious doctor was forced to complete an assault course with a midwife, as part of a management training course.

> ... the coup de horreur was the discovery on the final day, that Hepatticus must do a three-legged assault course, tied by the ankle to a senior midwife. Can there be anything closer to a definition of hell? How is one meant to work with someone who refused to follow any simple instruction because she is a 'practitioner in her own right' but who seemed incapable of doing anything practical at all? A woman who at the first sign of difficulty denied all responsibility and pleaded with Hepatticus to take over... (Fawdry, 1994:302)

Fawdry (1994) goes on to suggest that although many midwives are content to work as obstetric nurses, others could extend their role to provide care for complicated cases and undertake procedures such as ultrasound scans, ventouse deliveries and caesarean sections. In doing so, they could enhance their status and meet the needs of

women who experience complications during the childbirth process. Indeed, although this reference is fourteen years old, it is still pertinent today.

More recently, McKenna *et al.* (2006) undertook a study to explore issues that arise from the introduction of innovative nursing and midwifery roles, from the perspective of health care managers. Semi-structured interviews were carried out with Chief Nurses (n=4), Directors of Primary Care (n=4) and Directors of Nursing (n=18) from Northern Ireland. The study found a lack of infrastructure to support new roles and the need for appropriate clinical supervision to avoid isolation. It was the view of respondents that new roles need to be identifiable as nursing or midwifery roles, rather than just being technical assistants to medical staff. It also identified that such roles necessitate the delegation of basic aspects of nursing and midwifery work to Health Care Assistants or MSWs. In spite of these concerns, it was felt that these new roles benefit patient care and assist with overall professional development. Although this was a small study its findings are similar to other studies into this subject such as Woodward (2004) and Ball (2005).

Lavender *et al.* (2002) describe a study undertaken to provide an overview of midwives' opinions about expansions to their current role, following the recommendations of *Making a Difference* (DoH, 1999a). Questionnaires (n=735) were sent out and were completed by 66.4% of respondents (n=468). This paper reports the findings from data gathered from the free-text spaces, which were completed by midwives (n=396). The midwives generally felt that they had an impact on long-term health outcomes but they were concerned that if the midwives' role continues to expand, it may result in the disintegration of their existing role. While they valued the opportunity to improve the provision of holistic care, there was a concern that their overall role may become too diverse, and that this could result in reduced standards of care and too much pressure being placed upon them. Midwives were aware that they were working at a time when there was an opportunity to develop the services they provide, but were worried that any such development might encroach on other aspects of their work. One of the main areas of concern was the issue of appropriate resources for any changes, including adequate financial incentives for midwives who extend their role.

In Wales, The National Leadership and Innovation Agency for Healthcare (NLIAH) (2007) developed a structured process for planning and developing new roles. The process considers the needs of the service and other stakeholders, ensuring that any necessary changes were made prior to introducing the redesigned role. This provided a proactive approach that aims to prevent rather than solve issues. However, changes that occur in the NHS are usually made in response to gaps in service or changes to care needs and have traditionally been undertaken within very tight time frames. This hurry and urgency might hinder full compliance with the process as it is outlined in the document.

Midwives have extended their role in a number of ways. Specific extensions of the midwives' role, to undertake work previously carried out by medical staff, are discussed in detail below.

2.4.4 Neonatal examination

The routine neonatal examination is generally accepted as good practice but the value of this examination has also been called into question (Hall, 1999). The reduction in junior doctors' working hours, along with the increase in the number of midwife-led units and a lack of GPs skilled in performing neonatal examinations, has resulted in midwives extending their role to fill this gap in service provision. There is a need to establish which professionals are best placed to undertake this examination and to develop appropriate training programmes to ensure a high standard of care (Sherliker, 1997; Lomax, 2001).

Townsend *et al.* (2004) undertook a robust and comprehensive research project for the National Health Service Health Technology Assessment Programme, to compare the routine neonatal examination performed by specifically trained midwives and paediatric senior house officers (SHOs). This was done to assess the implications and cost-effectiveness of midwives extending their role in this manner. A series of published papers resulted from this study (Wolke *et al.*, 2002; Rogers *et al.*, 2003; Bloomfield *et al.*, 2003), of which there were many different aspects. A prospective randomised control trial was undertaken with mother and baby dyads randomised for

examination by midwife or SHO and a sample of the examinations was video-recorded and assessed. Health professionals and mothers were interviewed in order to obtain qualitative data regarding their opinions, and interviews were also undertaken with representatives from consumer and professional organisations. Cost implications were assessed and a national survey was conducted to gather data on current practice. The randomised control trial was undertaken at a District General Hospital, GP surgeries and in women's homes. Additionally, the questionnaire was sent to all maternity units in England.

This study concluded that there was no statistical difference between the midwives and SHOs with regard to appropriate referral rates, and the video assessments found that examinations by midwives were done appropriately. The quality of the examinations undertaken by midwives was rated as good or very good by paediatric consultants for 23% of the examinations, and by the midwife raters for 23% of the examinations. Twelve percent of the midwife raters and 0% of the paediatric consultants rated the examinations undertaken by the senior house officers as good or very good. Maternal satisfaction with the conduct of the examination was 81%. Mothers were more satisfied when a midwife undertook the examination, as it was reported that the midwives imparted more information and provided greater service continuity. None of the representatives of the professional or consumer organisations had concerns about midwives undertaking this role, and it was established that there would be a £2.5 million saving if midwives undertook all neonatal examinations. Results from the national survey found that 44% of units employed midwives who had received the training needed to undertake this examination, but that midwives nationally undertook only 2% of examinations. A need for further research to establish the criteria that would decide midwives' involvement in neonatal examinations was noted.

Mitchell (2002a and 2002b) undertook an insightful qualitative study using a grounded theory approach, to gain an understanding of midwives' experiences in undertaking neonatal examinations and to identify factors that promote or constrain midwives who undertake this extended role. Interviews were carried out with midwives (n=19) who had received training to conduct the routine neonatal examination, and the study found that this development resulted from a gap in service

provision. The midwife participants held the view that the majority of medical staff saw this development positively, although some GPs felt that it encroached upon their role. Midwives felt that they were the most suitable health care professionals to conduct this examination and that the mothers were happy for them to do it. The reasons given for this were improved continuity of care, and because midwives took the time to explain the examination and give health education advice. Another advantage of midwives undertaking neonatal examinations was that they could perform the examination at a time that was suitable for the women, thus avoiding delayed transfers home. The midwives also reported improved job satisfaction and that they enjoyed the extra responsibility, but mentioned concerns over the possibility of missing abnormalities during the examination. The midwives viewed the neonatal examination as integral to their role, though some felt that time constraints limited their ability to undertake this examination. In some maternity units, medical staff undertook the responsibility of assessing midwives' ongoing competency at performing this examination, which may be inappropriate, as it demonstrates the control of doctors over the midwifery profession. It is also questionable why midwives are expected to extend their role to fill the gap in service provision, when they appear to have inadequate time to perform this examination in addition to their own work.

Lumsden (2005) carried out a study to investigate how midwives perceive the examination of the newborn as an additional aspect of their midwifery practice. This qualitative study used interviews with midwives (n=10) from a maternity unit in the West Midlands. The midwives felt that undertaking the neonatal examination had been incorporated into their usual midwifery practice and that it had enabled them to provide holistic care. They expressed the view that this extension of their role helped them deliver midwife-led care and resulted in greater job satisfaction. Although they were initially nervous about undertaking neonatal examinations, after examining at least a hundred neonates as part of their course, they felt their competence had increased and they saw themselves as being more autonomous and accountable. This was accompanied by concerns over litigation, though this reduced as they became more experienced. The clients were perceived as being happy with the midwives performing the examination, but a few wanted to see a doctor at some stage in their postnatal care. The midwives stated that the junior doctors had little training in

carrying out neonatal examinations and thus lacked the necessary skills – as did some GPs.

The midwives in this study found themselves being asked for advice by other midwives and junior doctors, in turn, they found the help and advice of the ANNPs invaluable but there was a tendency for other midwives and medical staff to expect these midwives to undertake examinations on babies who were not from their caseload and they were often called to other departments for this. They reported that they had to develop their assertiveness skills in deciding when it was appropriate to agree to this, and agreed only when it was in the clients' best interests. Concern was also expressed that they had to demonstrate ongoing competence by performing neonatal examinations on at least 35 babies a year, although this was not expected for any other aspect of care they provided. Another issue that caused concern was the lack of rights to refer directly to a senior paediatrician or to order investigations themselves.

This review found a number of good quality studies concerning this subject, however, the study by Townsend *et al.* (2004) was the most in-depth and provided valuable information for those who procure and deliver healthcare services. There is consistency among the findings of the studies reviewed. It appears that midwives are able to successfully extend their role to perform neonatal examinations but, if this is to be continued, there may be a need to increase midwifery staffing levels to ensure that standards of care provision are maintained. A review of the literature on this subject confirms that although paediatric junior doctors lack expertise in performing neonatal examinations, constraints seem to apply only to midwives. In some units, criteria exist outlining the fact that midwives can only examine 'normal neonates'; in other units, midwife competence must be demonstrated on an ongoing basis. In addition, the systems have not been altered to allow midwives to make referrals or to order investigations. It appears that even when evidence exists that midwives are able to perform neonatal examinations competently, constraints to midwives' autonomy of practice can still exist.

2.4.5 Ventouse delivery

The need to extend the midwives' role to undertake ventouse deliveries and work as MVPs resulted from the same factors that led to midwives undertaking the neonatal examination. It has been acknowledged for some time that vacuum extraction, using a silc cup, is a method of assisted delivery with a low level of risk for both women and babies. A meta-analysis of six randomised controlled studies – comparing ventouse and forceps deliveries – shows that delivery using ventouse results in lower levels of morbidity (Johanson, 1993).

Rajkhowa *et al.* (1995) carried out a study to ascertain whether obstetricians and midwives thought that midwives should perform vacuum extractions (ventouse delivery). A questionnaire was sent to all consultants (n=81) and senior registrars (n=12), along with labour ward managers and senior midwives (n=41) from the West Midlands region. The response rates were: consultants, 63%; senior registrars, 8%; and labour ward managers and senior midwives, 29%. Sixty-eight percent of respondents stated that midwives should perform vacuum extractions; 40% stated that they should not undertake this procedure, and of these, 23 were consultants, two were senior registrars, three were labour ward managers and three were midwives. Fifteen of these stated that they were prepared to reconsider their view if there was evidence regarding the safety and practicality of this development.

The respondents of this study who felt that midwives should extend their role in this way (89%) stated that it would be appropriate to undertake a 'lift out' using a silc cup. Seventeen percent stated that midwives should be able to perform a mid-cavity vacuum extraction using a silc cup and 13% stated that they should be allowed to perform a mid-cavity and rotational delivery using a metal cup. Midwives were deemed suitable by 68% of respondents to undertake delivery of only occipito-anterior positions, and although 60% agreed that midwives should be able to administer a pudendal block, most agreed that it would not be necessary for a 'lift out.' Only 17% thought that a registrar would need to assess cases prior to midwives undertaking the vacuum extraction and 81% felt that midwives should be able to deliver both primiparous and multiparous women. However, 21% felt that there might be a significant legal risk if midwives performed vacuum extractions. The main

reasons given by those who thought that midwives should not perform vacuum extractions were: lack of training, reduced experience for junior doctors, medicolegal concerns and the possibility of increased interventions. A limitation of this study is that as this study used a questionnaire, there was no opportunity to explore in detail the views of the respondents but this could be addressed in a later, qualitative study. A more serious limitation is that it sought only opinions in the abstract so none of the respondents had any responsibility for putting such a system in place, nor for following it through. Indeed, in 1995 the midwives of only one maternity unit in the UK undertook vacuum extractions, so it is perhaps understandable that respondents were concerned about a development that none of them had experienced.

Hayes (1997) describes the introduction of a service that involves a select number of midwives being trained to undertake ventouse deliveries, at a maternity unit in South East England. This initiative was proposed following the publication of *The Scope of Professional Practice* (UKCC, 1992), in an effort to reduce the number of women who had to be transferred from midwife-led to consultant-led care during labour. Both obstetricians and midwives were reported to be supportive of the five midwives who undertook ventouse deliveries. However, most of the other midwives in the unit did not want to extend their role in this way and they spoke of criticisms of this development that they had heard from midwives who worked in other units. An audit of the first 144 women who had a ventouse delivery performed by a midwife showed that this development had not adversely affected the outcome. Hayes (1997) points out that the development of the midwives' role should be based on women's needs during childbirth, rather than on the confines of the midwives' traditional role.

Tinsley (2001) describes the development of an MVP service in southwest England. This area has seven stand-alone community maternity units. These were originally GP units, but by the early 1990s only a few of the local GPs wanted to provide intrapartum care. Gradually these units became midwife-led, and the reasons for this were similar to those described by Hayes (1997). Tinsley (2001) acknowledged the debate within the midwifery profession regarding this development. Concern had been expressed about whether it would be detrimental to the role of the midwife and whether it might result in unnecessary medical interventions. Conversely, it had been argued that it would increase midwives' pride in their profession and increase clients'

satisfaction with the care provided. It was reported that this development resulted in the intrapartum transfer rate from midwifery led units decreasing by 16%; additionally, women and their partners expressed satisfaction with this service. Tinsley (2001) comments that in retrospect, formal training should have been put in place at the start of the MVP service but this might have caused delays in initiating the development. She mentioned some concerns in sustaining this service, e.g., the financial implications of training and updating MVPs and balancing the training needs of all groups of students.

Wills and Deighton (2002) describe an initiative to develop the role of the midwife in undertaking ventouse deliveries, forceps deliveries and fetal blood sampling. The decision for this extension of the midwives' role came about as a result of recent changes to the patterns of working hours and training for obstetricians, which created a gap in obstetric service provision. Selection criteria and a protocol were developed and a university-based module for instrumental deliveries had been planned. A midwife who had undergone training to perform these procedures reported that her skills and confidence had improved, and she commented on the support she received from her supervisor. It was noted that women tended to feel that they had experienced a normal delivery when a midwife had performed an assisted vaginal delivery. It was also reported in the paper that the training course was still waiting for validation and the Trust had not yet formally agreed to provide vicarious liability for this extended role. As no other papers relating to this development were identified in the literature, the success of this extension of the midwives' role is undetermined.

Alexander *et al.* (2002) undertook a study to evaluate an MVP course and participants' perceptions of how it had affected their practice. Initially, a focus group was held with midwives (n=8) who had completed the first course one year earlier. This was followed by a questionnaire, which was sent to all midwives (n=18) who had undertaken an MVP course. The participants were from community maternity units (n=11) or a consultant-led unit (n=7). A total of 505 women had been referred to the MVPs, although one midwife had not yet had the opportunity to conduct a ventouse delivery. The outcomes for the clients were: ventouse delivery by MVP, 72%; normal birth, 26%; and needed the assistance of an obstetrician, 2%. In this study, the MVPs appeared to be committed to avoiding unnecessary interventions

during childbirth. It was also reported that when an MVP performed a ventouse extraction, as opposed to an obstetrician, the environment was calmer and the woman was more likely to feel that she had experienced a normal birth. The study found that intrapartum transfers from the community units had been reduced and the midwives reported an increase in their confidence and skills.

Charles (2002) describes her experience of practising as an MVP in an isolated community maternity unit.

> On walking into a birthing room when the desperate hopeful eyes of a woman and her partner (and sometimes the midwife) turn to me. I sometimes feel like the cavalry coming over the hill, consisting of only one soldier. (Charles, 2002:75).

However, the decision-making involved in assessing whether a ventouse could be performed was said to be more difficult than undertaking the technical process of actually performing the ventouse delivery. The difficulty of deciding whether to undertake a ventouse delivery when the case did not meet the agreed criteria, but prolonged fetal distress was present, was explored in detail. In every such case where a ventouse delivery has been undertaken, the risk manager of the Trust was notified that there had been a deviation from the protocol. In all of these cases, the midwives had been reassured that they had acted appropriately and it was felt that if the decision were made not to undertake a ventouse delivery, the risk management team would be equally supportive. The issue of failing to perform a ventouse delivery successfully, resulting in the transfer of a woman to the consultant unit, was discussed. Although the number of such cases was low, it was felt that this might lead to a crisis of confidence and that the MVPs value the opportunity to have reflective practice and support from colleagues.

Charles (2002) also states that the views of other midwives who did not want to take on this role – or who felt that midwives should not be developing in this way – should be respected. The view was expressed that MVPs try to keep the birth process as normal as possible and that the selection process must ensure that only midwives who use this approach carry out this role. It was pointed out that the status of MVPs should not be elevated and that although they are using their midwifery skills to carry out

ventouse deliveries, they nonetheless remain midwives. Similar experiences have been reported in other papers (Mulholland, 1997; Parslow, 1997; Charles, 1999).

Although there are a number of publications dealing with this issue, it appears that they all originate from a small number of maternity units in England. There have been no exploratory studies into this role or quantitative studies into its effectiveness. Nonetheless, the literature does indicate that midwives are able to successfully extend their role to undertake ventouse deliveries, while still trying to maintain normality during the childbirth process.

2.4.6 Undertaking traditional obstetric roles

Wells (2003) describes the 'first on-call project', which began in 1998 in a district general hospital in Northeast England. This project involved midwives and gynaecology nurses undertaking the role of junior doctors in obstetrics and gynaecology, between the hours of 5 pm and 9 am. These duties were undertaken in addition to their normal workload. Specific 'in-house' training was provided, but no additional financial remuneration was paid. This initiative commenced in order to reduce costs, the number of locum doctors employed, junior doctors' working hours, eliminate duplication of work and extend midwives' and nurses' roles in improving continuity of care. Two audits were undertaken that found this project to be successful in meeting its aims. However, this project has caused additional stress for staff and necessitated community midwives being called in to the unit during times of increased activity, to ensure the provision of safe care. Health care assistants have also been employed to assist with increased workloads. Although this project was reported to be working well, it does appear that the midwives are undertaking the work of medical staff while having to delegate their midwifery duties to untrained staff.

Ramsey and Paine (1997) described the extension of the midwives' role to assist with caesarean sections at a maternity unit in Southwest England. This development occurred in order to improve training and reduce the working hours for junior doctors. This was achieved by developing rotas where the trainee GPs do not work after 10 pm at night, by redirecting, whenever possible, 'out of hours work' to daytime clinics and

by providing 'in-house training' to midwives who volunteered to learn to assist at caesarean sections. Apparently this service does not compromise the provision of safe care, for if a midwife is not available, the consultant on call is called in to the unit. However, unless they are resident in the unit for their on-calls, this is unlikely to be an option in an emergency situation. It was felt that although this development was effective, there were still some disadvantages. Both the middle-grade obstetricians and the midwives reported that their workload had increased, but this was said to be minimal. It was also felt that there was a need to ensure that junior doctors receive adequate opportunities for training, whilst still ensuring that they continue to feel part of the team. This development appears to be meeting the needs of junior doctors, while increasing issues for midwives and negatively affecting the safety of care provision.

Harvey (1995) carried out an ethnographic study to explore the role of technology as a resource in the structure of the medical domination of birth and death, while stressing the pivotal position of technology at the intersection of control and uncertainty. Data were collected using observation and semi-structured interviews in two intensive care units and a consultant-led labour ward. Nine months were spent in the intensive care unit setting and eight months in the maternity ward setting. Interviews (n=124) were undertaken with health care staff, clients, and relatives of ex-patients from the intensive care units. This study found that the extended role of intensive care nurses and midwives represents the sub-contraction of selected tasks to the subordinate nursing and midwifery professions by the dominant medical profession, who retain ownership and control of the management of care. The extended role of the midwife was perceived as serving to move midwives from their traditional role and incorporating them into the medical model of care and the overall medicalisation of childbirth.

The midwives in this study found themselves pressured by the demands of service delivery and the unwillingness of medical staff to be present in the units to accommodate the workload. This resulted in midwives absorbing certain aspects of the workload of the medical staff without financial reward, recognition, increased autonomy, or an increase in staffing levels. This may result in the work of midwives being delegated to untrained staff and an increase in the pressure and stress

experienced by midwives. The extended role of the midwife achieves both an increase in patient throughput and an extension of medical treatments and interventions during childbirth, without doctors having to carry out the extra work themselves. It appears that the midwives generally see the extended role as improving holistic care and continuity for clients, but there was some concern that the essence of the role of the midwife could be lost and midwives could find themselves becoming obstetric nurses. Concern was also expressed about the consequences of mistakes being made or complications developing, and how well the midwives would be supported in litigation cases. In any case, it was felt that midwives might not have the power to resist a further extension of their role (Harvey, 1995). Although this is a relatively old study it does provide some useful insights into this subject.

In most instances where midwives have extended their role, it seems that it has been done not because areas have been identified where midwives could improve care for clients, but to ensure that services, which are no longer being provided by others, can continue to be offered. Although midwives are as capable of undertaking these additional aspects of care as doctors, generally they have to work with strict criteria and protocols and to demonstrate their competence to medical staff on an ongoing basis. Consequently, although midwives have extended their role, restrictions to their practice remain. Healthcare policy has seemingly allowed midwives more autonomy in that they are able to undertake certain aspects of medical care. However, this has also allowed obstetricians to the fill gaps in service provision while successfully maintaining control over maternity care and without increasing their workload. Conversely, these developments have increased the workload of midwives without any apparent increase in their autonomy or staffing levels. In some cases, this has resulted in aspects of midwifery practice having to be delegated to untrained staff. Generally, these extensions to the midwives' role would appear to have benefited obstetricians more than midwives.

The studies identified in the literature concern midwives extending their role, while continuing to work as traditional midwives. MPs undertake only the extended aspect of their role which may allow them to increase their autonomy, but will also result in them encroaching upon the dominance of the medical profession. Cahill (2001) argues

that if midwives begin to practise in a way that poses a threat to the medical profession, they may find their power curtailed.

> The extent to which such challenges to traditional medical boundaries will be accepted depends upon existing power relationships... Such an expansion of midwifery would enhance partnerships between midwives and women to the extent that they would threaten the obstetricians' power base. (Cahill, 2001:341)

Though MP roles are a relatively new development in the UK, new and extended nursing roles such as Nurse Practitioner (NP) posts have been in existence for a number of years. Therefore, there is a more comprehensive range of both qualitative and quantitative research in this area, which can be useful when considering the MP role.

2.4.7 Extended nursing roles

Background

Shortages in the medical workforce have also resulted in increasing demands upon nurses to extend their role and undertake medical tasks such as neonatal care and accident and emergency (A&E) care. This has resulted in fluidity of roles within the NHS in order to ensure gaps in service provision are filled by the cost effective and clinically effective deployment of limited healthcare staff. Nurse Practitioner (NP) roles have been developed in response to this need (NHSME, 1991; DoH, 1993b, NHSME, 2003). This role combines nursing and medical skills and consequently poses a challenge to occupational boundaries (Barton, 2006). As the types of NP roles vary greatly it is difficult to define this group of nurses (Cullum 2005). While some NPs undertake specific technical tasks such as cardioversion (Currie *et al.*, 2004), others are faced with more complex and diverse challenges regarding assessment and multifarious decision-making, such as those undertaking triage in A&E departments (Dolan *et al.*, 1997).

NPs have been established in the UK for approximately twenty years, while in other countries such as the USA they have been established since the 1970s and their numbers are still increasing (Johnson *et al.*, 1979; Glynn, 2006). However, for the

purpose of this review, only UK studies are included, as other health care systems may differ considerably from those of the NHS. This section includes papers on the definition and effectiveness of NP roles and as MPs work exclusively in the acute setting, providing complex care for clients, this review concentrates primarily on studies, which consider acute care provision.

Definition of NPs

The RCN (2007) has developed domains and competencies for NPs (see Box Three). This was undertaken in response to the debate about advanced nursing practice, including their necessary academic levels, the implementation of the Knowledge and Skills Framework (DoH, 2004), and the NMC's Consultation on a Framework for the Standard of Post-Registration Nursing (NMC, 2005).

Box Three: The domains into which the competencies for NPs are grouped

Management of client health status The nurse - client relationship The teaching – coaching function Professional role Managing and negotiating the health care delivery system Monitoring and ensuring the quality of health care practice Cultural competencies RCN (2007)

These competencies have been used as the standard for the NMCs 'Standard for Advanced Nurse Practitioner Regulation Proposals' and for a number of NP education programmes in the UK. The International Council of Nurses (ICN, 2002) has outlined the specific characteristics of the NP role (see Box Four). The findings of a number of studies into the features of the NP role have identified characteristics similar to those outlined by the ICN (Hicks and Henessy, 1998; Offredy, 1998; Torn and McNichol, 1998; Kinnersley *et al.*, 2000 and Roberts-Davis and Read, 2001).

Box Four: Specific characteristics of the NP role

Integrating research, education, practice and management
A high degree of professional autonomy and independent practice
Case management and own case load
Advanced health assessment skills, decision-making skills and diagnostic reasoning skills
Recognised advanced clinical competencies
Provision of consultant services to health providers
Plans, implements and evaluates programmes
Recognised as a first point of contact for clients
ICN (2002)

Ball (2006) undertook a large survey of NPs on behalf of the 'RCN Nurse Practitioner Association.' This comprised a postal survey of 3,196 of its members, with a 38% response rate. Two-thirds of NPs worked in primary care and 95% of NPs felt their role allowed them to progress their careers whilst remaining in clinical practice. The majority of NPs reported that the core aspects of their role include: taking medical histories, undertaking physical examinations, assessing health needs, making diagnoses and taking autonomous decisions. Almost 72% hold a degree, with an additional 10% working towards achieving one. Generally NPs considered their professional judgement was respected by nursing staff (95%) and by medical staff (91%). Although 98% were able to make referrals, 44% reported difficulties in doing this and one in four felt that the full potential of their role was not being utilised. With regards to job satisfaction 92% felt part of a team, 85% felt their work was valued and 81% reported that they found their work satisfying.

Nevertheless this survey highlighted some negative aspects to the role, as the NPs reported feeling somewhat isolated and described their posts as being unique within the organisations in which they worked. There was also some uncertainty about the future of this role with 21% of NPs based in the hospital setting reporting that they felt their jobs were under threat. The reasons for this were not outlined, other than financial constraints and it is unclear whether there were other concerns relating to this role. Though this study brings to light a number of important issues, the use of a questionnaire meant that these could not be explored further, which somewhat limited the findings of this important study.

Another study by Ball (2005) found that there was a need for support for new nursing and midwifery roles and that the organisational infrastructures had not been developed in line with new roles and ways of working. This study also identified the need for appropriate clinical supervision to avoid isolation. Barton (2006) undertook an ethnographic study in South Wales to scrutinise the experience of students, teachers and clinicians involved in a BSc course for NPs. This study highlighted the confusion over the titles for advanced roles and the lack of structure and professional career frameworks for those working in advanced nursing practice roles.

In summary, the definitions of NP roles are somewhat generic, but NPs specifically provide care previously undertaken by medical staff and have a high level of autonomy and independence, though systems have not yet developed adequately to support the role. It appears that although the role of NP has been in existence for a number of years, ambiguities about it remain and there are still barriers in place, which prevent NPs from reaching their full potential.

Clinical and cost effectiveness of extended and NP roles

There has been a great deal of research into the NP role, particularly in relation to considering its clinical and cost effectiveness. Much of the research into this role concerns primary care settings. NP roles began to proliferate in primary care in the late 1980s, when they were recommended by the *Cumberlege Report* (DoH, 1986). Research into NPs in primary care using randomised controlled trials, systematic reviews and qualitative methodologies, has generally found that care provided by NPs is safe, acceptable and potentially cost-effective (Ashburner *et al.*, 1997; Horrocks *et al.*, 2002; and Venning *et al.*, 2000). A comprehensive range of good quality research studies has also identified similar findings in acute settings (Dolan *et al.*, 1997; Pioro *et al.*, 2001). There have also been a number of studies with similar outcomes into the advanced neonatal nurse practitioners role (ANNP) in neonatal care (Chan and Hey, 2006). It is however, acknowledged that it is more difficult to attribute outcomes to different groups of staff in acute settings, as a result of the complex nature of systems and care provision.

Sakr *et al.*, (2003) completed an in-depth study into the clinical effectiveness and costs of minor injury services provided by NPs, with minor injury care provided by an A&E Department. The authors undertook a three part prospective study in a hospital in the North of England where the A&E Dept. was closing and was being replaced by a nurse led minor illness/injury unit (MIU). The first part of the study comprised a sample (n=1447) from the original A&E Dept. and the second a sample (n=1315) from the new MIU, in order to compare clinical assessments. The third part assessed the costs of both models of care. The study concluded that the MIU provided equivalent or better care, with error rates in the MIU 9.3% and in the A&E Dept. 13.2%. Waiting times in the MIU were lower (mean MIU 19mins, A&E 56.4 mins). However, revenue costs were greater in the MIU (MIU£12.7 and A&E £9.66 per minor injury case). The referral and follow up rate was greater in the MIU (referrals MIU 47% and A&E 27%). It seems from this study that nurse- led MIU care provides safe care, but has higher costs and places greater demands upon outpatient services. The higher number of referrals by the NPs may have been appropriate, considering the lack of available senior doctors who could have been consulted for advice and support, however, this study did not look specifically at the appropriateness of referrals. In addition, there was no follow up of patients to assess outcome measures.

A paper by Dolan *et al.* (1997) described an evaluation of the work of NPs in A&E Departments and Minor Injury Units (MIUs) across London. Data were collected using interviews, questionnaires and focus groups. The study found that NPs were accepted by patients and staff, however, the scope of the roles varied considerably. The authors concluded that training issues needed to be addressed and the role defined. There were some limitations of the study, which included the short timescale, the diversity of the research sites and the differing data sets from the various units, which affect the conclusions that can an be drawn from this study. Chan (1996) undertook a small scale study using postal and telephone questionnaires to evaluate the perceptions of nurses (n=130) and junior medical staff (n=12) about the role of night nurse practitioners, who combine aspects of the night nursing administration role and the junior doctors' role. The study found that both groups felt that this role benefited patient care, staff development and reduced the number of calls doctors received during the night. Although this paper did not describe how the night nurse

practitioners coped with the increase in their duties and responsibilities, in addition to their existing role.

Venning *et al.*, (2000) conducted a randomised controlled trial to compare the cost effectiveness of GPs and NPs as the first point of contact in primary care. The study was undertaken in 20 GP practices in England and Wales, with a sample of 1292 patients randomised to be seen by either NPs (n=641) or GPs (n=651), who contacted the surgery to request an appointment the same day. The study found that with regards to health status and patterns of prescribing there was no significant difference. The patients reported more satisfaction with NP care (mean score 4.40 v 4.24 for GPs; adjusted difference 0.18, 0.0920 to 0.257). NP consultations were longer (11.57 v 7.28min; adjusted difference 4.20, 95% confidence interval 2.98 to 5.41). They also carried out more tests (8.7% v 5.6% of patients; odds ratio 1.66, 95% confidence interval 1.04 to 2.66) and asked patients to return to the surgery more often (37.2% v 24.8%; 1.93, 1.36 to 2.73). This study found no significant difference in costs (NPs £18.11 v GPs £20.70; adjusted difference £2.33, - £1.62 to £6.28). However, the authors concluded that although the costs of consultations were similar, NPs would need to shorten their consultation times and reduce their return consultation rates in order to be more cost effective than GPs.

Raftery *et al.*, (2005) undertook a randomised controlled trial and a cost effective analysis in order to evaluate nurse led secondary prevention of coronary heart disease. The authors concluded that this type of care provision was highly effective, as there were fewer deaths and improvements in patient lifestyles, however, the cost per patient was £136 more in the intervention group, but this did not consider possible long-term savings. Walsh *et al.*, (2005) carried out an evaluation of nurse led intermediate care in an acute setting. This role is complex and requires diverse decision-making. A cost minimization analysis was undertaken, by treating the nurse - led intermediate care and the standard hospital care as being equivalent and simply totaling up the costs for each and comparing costs. This study found the nurse led service to be more expensive, however, this simplistic approach did not consider improved outcomes of care and the long-term financial implications of ongoing care such as readmission costs.

The Walsh trial was included in a meta-analysis of nurse led intermediate care, which comprised 10 studies, and found a number of benefits of nurse led care such as reduced readmission rates, and numbers of patients discharged to nursing homes, along with improved health status on discharge, all of which could result in long term financial savings (Griffiths *et al.*, 2004). Davies *et al.* (2001) undertook a prospective, open, randomized controlled trial into the effectiveness and cost implications of a hospital diabetes specialist nursing service, which found that this service was cost effective, as it resulted in reduced hospital lengths of stay. This service was also found to increase patient satisfaction and knowledge about diabetes. Although these studies indicate that nurse led services have improved patient care, comparisons with MP posts should be made cautiously, as there are differences in the type of work undertaken by these different healthcare workers and these studies relate to intermediate rather than acute care provision.

It appears that there are wide variations in the types of roles undertaken by NPs and nurses working in extended roles, and that issues surrounding their training still need to be addressed. The literature shows that NPs have been successful in reducing the work of junior doctors and it seems that this role provides improved levels of care. Unlike other extended roles, NP posts are generally developed in addition to existing staffing levels, so there is adequate time to undertake the role. Although the literature may demonstrate that NPs are more thorough, it may also indicate that they lack confidence and are unsure regarding their decision-making, resulting in longer consultations and higher rates of follow up appointments. It appears that there is little evidence to support the idea that the replacement of doctors with NPs can provide significant cost savings (Banham and Connelly, 2002). However, cost comparisons between NPs and junior doctors should be interpreted cautiously, because the roles differ in relation to hours of shifts worked and the scope of the roles, as the capacity of these roles has not been fully developed. In addition, it is difficult to estimate the long-term savings resulting from this role, both financial and in terms of the overall health status of patients.

Advanced Neonatal Nurse Practitioners (ANNPs)

The number of ANNPs is increasing in the UK and they undertake various aspects of the paediatricians' role including neonatal examinations and resuscitation. A number of good quality studies have been carried out concerning this role. Smith and Hall (2003) undertook a study in the South of England to determine the evolving role and scope of practice of ANNPs and to identify factors, which may influence future recruitment and retention. This study used questionnaires, which were sent to 95 ANNPs (response rate 83%). The study concluded that factors influencing job satisfaction included: working within a team of ANNPs, a well-defined role, support from the unit, continued professional development and appropriate remuneration. In addition, the study found that even though ANNPs are expensive to train and employ, they represent a good return on this investment in terms of retention in the speciality and service provided.

A study by Lee *et al.* (2001) compared the success of ANNPs and SHOs in undertaking the neonatal examination. A prospective study was carried out of all babies (n=527) referred to specialist orthopaedic, cardiac and ophthalmology clinics from two hospitals in England. In one of the hospitals, the ANNPs undertook the neonatal examinations, while in the other hospital this was carried out by the SHOs. The findings of this study showed that ANNPs displayed greater sensitivity than the SHOs (96% v 74%; $p < 0.05$) for hip abnormalities. The ANNPs were more sensitive for eye abnormalities (100%v 33%; $p<0.05$). No differences were noted in terms of positive predictive values or effectiveness in detecting cardiac abnormalities. These findings indicate that the ANNPs were more effective than SHOs in identifying abnormalities when undertaking neonatal examinations. There was a difference between the two maternity units where this study was carried out: one provided care for women at high risk of obstetric complications and had a neonatal unit on site, while the other did not. However, there were no differences between the two units with regard to the rate of abnormalities considered in this study. The findings of this study imply that there is a need to improve the training provided for paediatric SHOs; it also indicates a need to review workforce planning, as the number of nursing posts may need to increase to accommodate the increased demands this extended role places on ANNPs.

Chan and Hey (2006) conducted a large-scale study in the North of England to assess the ability of ANNPs to manage the care of newborn babies requiring resuscitation in a unit without on site medical assistance. A prospective review and selective external audit was undertaken of the medical records of the 14572 babies born in the maternity unit during the first eight years following the replacement of resident paediatricians with ANNPs. The results of the study found that ANNPs were able to successfully manage the care of neonates and that their skills at laryngeal intubation did not decrease over time, even though they were required to undertake this task on average once a year. A study by Yoxall and Aubrey (2001) also found that ANNPs can successfully manage neonatal resuscitation in large referral centres. While Platt and Brown (2004) undertook a comparison of quality measures on sentinel cases with five comparator hospitals using modified confidential enquiry criteria in North East England. The study found that ANNPs are able to deliver a high quality of neonatal care, without the assistance of resident junior paediatricians.

Woods (2006) carried out an investigation to establish if there was any preliminary evidence to indicate if the quality of care and clinical outcomes for premature neonates differed between NP and paediatric care during the first 6-12 hours following admission to the neonatal unit. This study employed a retrospective examination and quality assessment of casenotes and patient outcome data. It was identified that though ANNPs provided acceptable care they did not perform as well as medical staff with regards to completeness and comprehensiveness of care in the majority of cases. The study also found various deficits in the care provided by both groups of staff, indicating a need for further training.

Whilst it seems that NPs are able to provide safe, effective and acceptable care, they are able to provide the most cost effective and comprehensive care when working alongside medical staff. The literature suggests that midwives, who have extended their role, are dissatisfied with the restrictions to their practice imposed by medical staff. However, NPs who have the autonomy to practice without such restrictions continue to refer to senior doctors more frequently than do junior doctors. This may indicate a reluctance or lack of confidence to practice without deferring to the opinions of medical staff.

The lack of financial savings associated with this type of care compared with the care provided by doctors may have implications for the future of NPs. Nevertheless, it is unrealistic to anticipate that more junior doctor training posts will be developed, as this would limit opportunities for their career progression and could result in a surplus of doctors, who are very expensive to train. However, there are financial implications associated with such developments to the nursing role, as there is a need to employ more generalist nurses to replace those who extend their role or move into NP posts.

Conclusion

In conclusion, the papers that emerged from the literature review ranged from large randomised controlled trials (RCTs) to small-scale qualitative studies, though the majority of the studies reviewed were qualitative. The majority of the research papers reviewed were of a high standard, often the results of meta-analyses from established electronic databases such as Cochrane. After an examination of the relevant literature a gap was identified concerning the practice and policy literature in relation to the development of the MP role in Wales.

The literature review has shown that a number of changes have been introduced in maternity services with little consideration of their impact upon care provision or healthcare staff. Therefore, the need to consider and explore the impact of new roles such as MPs was highlighted. The literature review has shown that although there have been research studies into new nursing roles such as NP posts and extensions to the midwives' role, which have been incorporated into their work as traditional midwives, there have been no studies specifically looking at the MP role in acute obstetric and gynaecology services. Therefore, this study is concerned specifically with this role.

Healthcare policy has encouraged a proliferation in extended nursing, midwifery and AHP roles in the UK and a vast number of studies have considered this subject and provided evidence that those undertaking such roles are able to provide clinically effective care. The majority of studies into the NP role have been concerned with whether they are as clinically effective as doctors and whether the work undertaken by these new practitioners is likely to lead to significant cost savings. However, rather

than concentrating on whether NPs/MPs are as good or better than doctors, perhaps research should consider whether this role could offer more to clients in terms of quality of care and satisfaction levels. This might reveal whether NPs/MPs have just become substitutes for doctors or whether they are able to bring the unique perspectives of nursing and midwifery to this role. The current study considers this issue by exploring the MP role.

It is questionable whether such new and extended midwifery roles will improve midwives' autonomy and ability to accept responsibility, or whether such new roles will result in midwives becoming obstetric nurses with high levels of technical expertise but little autonomy. The literature demonstrates that midwives undertaking extended roles, have to work within strict controls and restrictions, imposed by medical staff, which impacts negatively upon their autonomy and job satisfaction. Conversely, NPs are able to work in an unrestricted way, but continue to refer more frequently to medical staff than do junior doctors. This may indicate that when NPs are able to practice autonomously they remain more comfortable in allowing doctors to take responsibility for decision-making. The current study will consider this issue.

MP roles differ in a number of ways from traditional midwifery practice and have a higher grade than other clinically based midwifery posts. The drivers for change that influenced this development include health service policy (NAW, 1999); the reduction in junior doctors' working hours, resulting in gaps in service provision (NHSME, 1991); and advice from the regulatory body for midwives, that they could extend and develop their role to improve care for women (UKCC, 1992). The MP is responsible for assessing, investigating and producing a management plan for care or treatment, but delegates the responsibility for the implementation of the care plan to other midwives.

As there has been no research into this new role, a qualitative, exploratory approach was considered the most suitable, while the use of ethnography allowed not only for the exploration of the MP role, but also for consideration of its impact upon midwives and obstetricians in the research setting. More detail on the approaches chosen for this study will be found in the methods chapter.

CHAPTER THREE – METHODOLOGY

A (researcher) is like a shipwrecked person who learns how to live in a certain sense with the land, not on it, not like Robinson Crusoe whose goal is to colonise his little island, but more like Marco Polo, whose sense of the marvellous never fails him, and who is always a traveller, a provisional guest, not a freeloader, conqueror, or raider.
(Said, 1994:44)

3.1 Introduction to methodology

MP posts are a relatively new development in midwifery practice; therefore, there has been little research into this role. It is important to assess aspects of the extended role of the midwife, to encourage good practice and establish an evidence base for further developments in midwifery practice. The need for research into the impact of new policy and practice initiatives in midwifery practice is acknowledged by government in the report *Achieving the Potential Through Research and Development:*

> Research into the changing role and function of nursing, midwifery and health visiting practice is vital to ensure fundamental standards are maintained, as new practices and roles are embraced. Therefore, agenda setting, commissioning and funding bodies need good information on the significant research topics in these fields. (WAG, 2003:4)

The research questions raised by the development of new roles in the midwifery profession are wide-ranging. After an examination of the relevant literature a gap was identified concerning healthcare policy and the extended role of the midwife in relation to the development of the MP role. As there has been no research into this new role, a qualitative, exploratory approach was the most suitable, while the use of ethnography allowed not only for the exploration of the MP role, but also for consideration of its impact upon midwives and obstetricians in the research setting. The aim of this study is therefore to explore the role of MP and its impact upon midwives and obstetricians in a maternity unit in Wales.

A qualitative approach was chosen for this study, as this is most suitable for the research purpose, which is to reveal new understandings. In addition, this is a new

field where not a lot is known, which makes a naturalistic approach more fitting. Ethnography was chosen as the research methodology, as the researcher wanted to study the culture of MPs working in a maternity unit setting. Therefore, the study uses a qualitative, focused ethnographic approach and was designed in three phases.

This chapter is divided into eight sections. The first provides an introduction to the methodology, and the second explains the choice of methods and methodological issues raised by the nature and context of the research. The third section discusses some of the ethical issues associated with this research. In the fourth section, the methods of sampling and recruitment of participants into the study are described. The fifth section details how the research was conducted. The sixth discusses the issue of reflexivity and the seventh describes the strategy for analysing the data. The final section addresses some of the methodological limitations.

3.2 Study design

3.2.1 Research paradigm

Intrinsic to any research study is the need to identify methods to produce information that will meet the aim of the study. Rees (1997) describes the study design as a blueprint the researcher follows throughout the study.

There are two main philosophical approaches towards reality and how knowledge is obtained. These two paradigms reflect the differences between quantitative or experimental research and qualitative or naturalistic inquiry. Experimental researchers believe that reality and the thoughts of individuals are separate and that the natural world can be studied and quantified; they believe that the truth and reality of the world can be discovered through unbiased quantitative measurement, and that it is objectively knowable. Naturalistic or qualitative research is based on the belief that an understanding of the natural world can be gained only through peoples' experience of it and that it is inevitably subjective. The specific research paradigm selected is determined by the researcher's orientation towards learning about phenomena, the

level of knowledge development, the purpose of the research and the research question itself (Rees, 1997; DePoy and Gitlin, 1998).

In comparison to quantitative data, qualitative data is richer, has greater depth and can provide accounts of people's experiences, attitudes and ways of life. In addition, a qualitative approach can uncover the motives and meanings behind social action (Haralambos and Holborn, 2000). Streubert and Carpenter (1999) outline the significant characteristics of qualitative research:

> A belief in multiple realities, a commitment to identifying an approach to understanding that supports the phenomenon studied, a commitment to the participant's viewpoint, the conduct of inquiry in a way that limits disruption of the natural context of the phenomena of interest, acknowledged participation of the researcher in the research, and the conveyance of an understanding of phenomenon by reporting in a literary style rich with participant comments. (Streubert and Carpenter, 1999:15)

The research design chosen is dependent on the research question at hand. Brink and Wood (1994) describe three levels of research question. Level-one questions are formed at an uncomplicated level, where there is little evidence about the subject in the literature; this type of question can usually be answered by using a survey or a qualitative design. Level-two questions are used when there is a basic amount of information about the subject in the literature. These questions will mention more than one variable and can generally be answered through the use of a survey. Level-three questions are appropriate when a comparison can be made between variables to establish the differences or to test a hypothesis.

As for the topic of the current study, there is little information in the literature about the role of the MP; this has resulted in the development of a level-one aim, which can be most appropriately answered by using a qualitative design, as a survey would not produce the depth of information required. This naturalistic approach fits with the purpose of the study, which is to reveal new understandings. In addition, the naturalistic approach fits with the researcher's preferred way of knowing, as it acknowledges the existence of multiple perceptions of reality.

3.2.2 Research methodology

Various qualitative methods were considered when designing this study. For example, phenomenology is used to gain an understanding of the lived experience of individuals. In phenomenological research, the researcher elicits and describes the life experiences of informants; such research focuses on the interpretation of everyday experiences and the meanings of these for individuals (DePoy and Gitlin, 1998; Streubert and Carpenter, 1999). This method was not selected, as it is concerned with the experiences of individuals rather than the culture within a group. Grounded theory was developed by Glaser and Strauss (1967) and aims to develop a theory about or a theoretically complete explanation of a particular subject. It uses a structured and constant comparison process for data gathering and analysis, which compares each datum to others to establish differences and similarities (DePoy and Gitlin, 1998). This method could have been used in this study, but it was felt that a focused ethnographic study was more suited to explore the culture of MPs working in a maternity unit setting. As new roles cannot be explored in isolation, there is a need to investigate the research setting as a whole.

The method of historical inquiry studies human behaviour in the context of an idea, person, place, event or institution in the past. Historical research creates new understandings and ideas about the past; when considering new developments, it is important to gain an understanding of the changes that have occurred in the midwifery profession (Polit and Hungler, 1997; Streubert and Carpenter, 1999). In this thesis, the historical perspective has been considered in the literature review, but the main focus of this study is the contemporary position of the midwifery profession, making this an adjunct rather than the main framework.

Action research is used to study a specific setting to identify and describe issues in need of change, to identify potential solutions and take action to implement them. Nonetheless, the remit of this research study is to gain an understanding of the impact of the extension to the midwives' role, rather than to suggest solutions (Streubert and Carpenter, 1999). Ethnography is used when the researcher wants to understand a culture or sub-culture, and following a consideration of all of the available study methods, ethnography was selected as the most appropriate method in achieving the

aim of the study, as it is able to describe and make explicit what is implicit within the culture studied (Germain, 2001).

The meaning of ethnography can vary and its definition is often contested. In spite of this it retains some distinctive connotations, though it has been recontextualized and reinterpreted to meet individual circumstances. Core definitions of ethnography are helpful in understanding this research method, but they cannot capture its meaning in all contexts (Atkinson and Hammerslay, 2007).

Spradley (1980) states that ethnography has a number of primary purposes: to describe alternative realities, to better understand complex societies and to understand human behaviour. Ethnography is described as 'a branch of human inquiry associated with the field of anthropology, that focuses on a culture (or subculture) of a group of people, with an effort to understand the world view of those under study' (Polit and Hungler, 1997:456). The term 'culture' is described by DePoy and Gitlin (1998:136) as 'the set of explicit and tacit rules, symbols, and rituals that guide patterns of human behavior within a group'. Streubert and Carpenter (1999:150) describe cultural knowledge as 'an understanding of the people, what they do, what they say, and how they relate to one another, what their customs and beliefs are and how they derive meaning from their experience'.

Ethnography is well suited as an approach for exploring complex clinical and organisational issues in health care, as it allows these subjects to be explored in a natural setting in context. Ethnography is also effective in studying unexplored subjects, and can produce valuable knowledge, which can influence the development of new health care roles, such as that of MPs (Allen and Pilnick, 2006). Though the findings of ethnographic studies are not generalisable, they can identify questions and hypotheses that can be investigated using other methods. In addition, ethnography allows complex professional relationships to be studied appropriately (Baillie, 1995; Savage, 2000). Ethnography is used in this study, as it is able to combine the perspectives of the researched and the researcher, and allow the researcher to explore the holistic nature of the research setting (Streubert and Carpenter, 1999).

In ethnographic study, the researcher has an outsiders' view or 'etic' perspective, but seeks to gain an insiders' view or 'emic' perspective of the culture. This is achieved by gathering and interpreting data obtained from members of the culture studied. The three main types of information sought by ethnographers are: cultural behaviour, cultural artefacts and cultural speech. To gain access to this information, the researcher must participate in the culture. Initially, the researcher observes the environment to gain insight into the social scene, then carries out interviews, undertakes participant observation and examines artefacts such as case notes. The researcher strives to discover tacit knowledge, or information so embedded in the experiences of a culture that even its members themselves are not consciously aware of it and therefore do not speak of it (Polit and Hungler, 1997, Atkinson and Hammersley, 2007). Observation is one of the main features of ethnography, as it is important to see what people actually do, rather than just relying on what they say, because there are often inconsistencies between what people think and feel and how they act (Giampietro, 2008).

Muecke (1994) describes ethnography as a description of a people with regard to how they lead their lives together within their environment. The ethnographer concentrates on the routines, rituals, customs and beliefs that comprise their 'common sense' about their world or culture. Ethnography allows the researcher to identify and gain an understanding of the ambiguities in meanings observed and to portray the cultural matters of the groups observed.

Ethnographers tend to use an open-ended approach, starting with an interest in an aspect of social life, then exploring a specific facet of this, defining and sometimes altering the focus of study as the research progresses (Crang and Cook, 2007). When in the field, the researcher uses skill and insight to collect and analyse data, as information is often gathered in informal and unscheduled ways (Agar, 1986). The term 'reflexivity' describes the mutual influence of the researcher and the informants upon each other, and a good ethnography will be explicit about the nature of the reflexivity that occurs during fieldwork (see sections 1.9 and 3.6). Ethnographies are neither wholly objective nor wholly inductive, but are shaped by both the conceptual stance and subjectivity of the researcher and the informants. Researchers should render the culture studied coherent to the reader; their role is to demystify and explain

in addition to describing. The purpose of ethnography, then, is to make the social action of a cultural group comprehensible to another group. A good-quality ethnography would be described by participants as providing a caring and honest description of them and their circumstances, demonstrating credibility, clarity and depth of description (Muecke, 1994).

Muecke (1994) also outlines the different kinds of ethnography. The first is classical ethnography, which describes the original structural-functionalist form. This is the holistic description of a group of people that is relatively bounded, geographically, socially or linguistically. This is produced through long-term participant observation and by establishing the credibility of the researcher with the participants. Systematic ethnography was developed by ethno-semanticists in the 1960s and focuses more on defining the structure of a culture, rather than on describing a people and their social interactions and artefacts. It aims to reveal 'the native point of view' and learn the cognitive maps that shape people's behaviour as members of their group or culture.

Weberians, namely Clifford Geertz, developed hermeneutic or interpretative ethnography, which aims to discover the meaning of observed interactions (Muecke, 1994). This school views good-quality ethnography as providing a 'thick description' of behaviour. Critical ethnography represents feminist and postmodernist thinking; feminist ethnographers are focused on minimising the exploitation of informants and of highlighting the oppression of the less privileged groups within society, while postmodernist ethnographers view the writing of ethnography as a creative process and are primarily concerned with the form of the description. Focused ethnography was developed in the health sciences (Muecke, 1994). These 'faster' versions of ethnography can also be conducted for non-academic purposes, such as programme development in health service provision. The aim of a focused ethnographic approach is to develop knowledge and practice.

Focused ethnographies are also described as mini or microethnographies that are content-specific and focused, as opposed to maxi or macroethnographies, which comprise long-term and broad investigations of complex societies (Leininger, 1985; Germain, 2001). Though the term 'focused ethnography' is more frequently used, as such studies tend to be topic-focused (Morse, 1991), focused ethnographies share a

number of characteristics with maxi or macroethnographies. For example, data are collected using participant observation in the natural setting and artefacts are examined to gain an understanding of the culture. However, they also differ in a number of ways. In a focused ethnography, the topic does not emerge as data collection proceeds, but is decided prior to commencing the study. Thus, researchers endeavour to answer planned questions in order to provide information that is expected to have practical applications for health care. Focused ethnographies focus on distinct issues within a specific context, are carried out within a well-defined organisation or community and are time-limited. Only a few informants are employed and purposeful sampling is used to ensure they have the required experience and knowledge. Data are generally gathered, by a single researcher, from semi-structured interviews and short periods of participant observation (Muecke, 1994; Roper and Shapira, 2000).

Both types of ethnography allow for the development of a deeper understanding of a culture by participating in events, observing the members of the culture and by asking those members about what was done and seen during fieldwork. This combines the researcher's outsider perspective with an insider's perspective of the culture; together, they can provide insights that neither the members of the culture or the researcher could have achieved alone (Werner and Schoepfle, 1987).

In this study, a focused ethnographic approach was chosen, as opposed to a traditional ethnography, as it is the most appropriate type of ethnography to address both the aim and the constraints at hand. This study meets the criteria of a focused ethnography in that it was undertaken by a single researcher, it was purposefully non-directed and the findings emerged from the cumulative analysis of the data. It was time-limited and employed focus group methodology – in addition to participant observation and interviews, which are the usual data collection tools employed in an anthropological ethnography (Muecke, 1994).

3.2.3 Reasons for choosing ethnography

Undertaking a PhD is a learning experience and when deciding which methodology would be best suited for this study, I considered other studies concerning the midwives' role and inter-professional relations, and found that ethnography had been used successfully in such studies. Barton (2008) describes ethnography as a suitable research methodology to study holistically the culture of complex organisations and occupational structures, which can provide insightful descriptions. Another feature that makes it a suitable choice for this study is its flexibility and adaptability when collecting data regarding participants' experiences and their interactions with others in the multidisciplinary team. The main aim of ethnography is the interpretation of a culture. Data are generated from the first-hand experiences of the researcher in the culture being studied, it can also generate descriptions of the various groups within the research setting and identify how participants are located within their cultural setting (Holloway and Todres, 2006). This makes it a suitable methodology to explore the role of MP and its impact upon midwives and obstetricians in a maternity unit of a Welsh District General Hospital. Hospital wards and units have proved rich sources of data for the exploration of the division of labour, as they comprise a complex range of occupational groups and activities. They therefore provide a valuable setting for investigating sociological problems or issues, such as the exploration of new roles (Allen and Pilnick, 2006).

A number of characteristics of ethnography, identified by Holloway and Todres (2006), make it a suitable methodology for this study: it is suitable for studying cultures related to nursing and midwifery, including routines, activities and rituals, along with the interactions between different groups. It also allows for the discovery of the *insiders' view*. In addition, it provides opportunities to explore opposing perspectives within the various groups. This makes it a suitable research methodology for this study, as it provides opportunities to explore and explain the role of MPs and their interactions with and impact upon other groups. The use of ethnography in this study enabled lessons to be learnt about changes to the midwives' role resulting from healthcare policy recommendations and their implications for practice. Laugharne (1995) also identified features of ethnography, which make it a suitable choice for this study: It allows a holistic approach to be taken, which accepts the complexity of

social organisations. It also enables an understanding to be gained of group identities, while allowing different professional groups to be studied in their natural setting, as it is impossible to gain an understanding of one specific role without reference to others within the research setting (Allen, 2003). In this study, clients, midwives and doctors were observed and interviewed, in addition to MPs, in order to provide a more complete picture than would have been available if only MPs had been included.

Another advantage of using ethnography is that it allows a clinical area to be studied *in situ,* by directly observing activities first hand, as they occur (Schwartzman, 1993). Explanations are a valuable aspect of ethnography, as it affords opportunities to gain an understanding of participants' perspectives and gain clarification of their meanings (Becker and Geer, 1957). The reliability of participants' accounts gained through interviews alone are subjective, can be open to question and can produce data which conflicts with what actually happens in practice (Svensson, 1996; Allen, 1997). This was particularly important in this study, as I work as a manager and was undertaking research in the unit where I was employed, which may have had an effect on participants' responses. Therefore, in this study interviews were combined with participant observation in order to actually see, as well as hear, accounts of events and relationships within the clinical area. The methodology of ethnography was employed, as this study necessitated consideration of social processes such as conversations, activities and decision-making, all of which are important in exploring new roles and midwife-doctor interactions (Hughes, 1988).

3.2.4 Data collection tools

Triangulation is a specific feature of ethnography (Baillie, 1995). This study uses triangulation methods at the data collection level. In this study, different data collection tools were employed for each stage of the study, but as Phase one looked at an issue that made it distinct from the other phases, the benefits of triangulation can mainly be seen in Phases two and three. In research, this is more about using a number of methods to ensure the accuracy of the results, rather than fact-checking (Denzin, 1970). Campbell and Fiske (1959) first used the navigational term "triangulation" in research; by using this the researcher is able to study the

phenomenon of interest from various vantage points, and thus produce a clearer understanding and confirm the validity of a study. Data were collected using three different data collection methods (see Table One), and the findings were compared from the different sources to enhance the accuracy of the interpretation of the data.

Consideration was give to a number of data collection tools when designing the study. This section examines the appropriateness of the choice of data collection tools for meeting the aim of the study, and explores the advantages and disadvantages of each of these tools.

Table One: Phases of the study

Phases of study	**Method of data collection**
Phase One	Focus groups
Phase Two	Participant observation
Phase Three	Semi-structured interviews

The study was conducted in three Phases. Phase one was undertaken first in order to place the findings of the rest of the study in context, as previous research considered midwifery practice in England rather than Wales. It also provided information on midwifery at that specific time. In addition, it provided a basic understanding of how midwives perceive the role of MP. Phase two was then undertaken in order to see and hear how MPs practice and how their role impacted upon midwives and obstetricians in the research setting. In Phase three I was able to explore these issues in more detail by asking clients, midwives and obstetricians about this subject and exploring further what I had seen and heard during Phases one and two. This allowed a clearer picture to be developed about this role and its impact upon the midwives and obstetricians working in the unit.

Phase one

Phase one of the study employed a focus group methodology. Data collection for Phase one of the study was carried out first in order to place this study in context. Generally speaking, participant observation and interviews are the main data collection tools used in ethnographic studies; however, in this study, a focus group

methodology was also employed, as the interaction between group members during focus groups allows for a full exploration of midwives' views. In this way, the group interactions and dynamics help participants explore and focus upon their opinions in a more effective way than would be possible in a one-to-one interview (Morgan, 1988; Morgan, 1997; Kitzinger, 1995). Focus groups were originally used in market research in the 1920s (Bogardus, 1926), but virtually disappeared for the next 30 years. When focus groups were employed, it was because of convenience, in that it allowed for a number of individuals to be interviewed together and could be used wherever the participants were likely to be. Work published by Morgan (1988) and Krueger (1994) renewed interest in focus groups and their use has increased in health care research over the last 20 years.

Morgan (1997) describes a focus group as an interview with a group of between six and 12 individuals assembled together and usually lasting between one and two hours. Purposive sampling is usually employed for recruiting focus groups, and it was used in this study to provide a homogeneous group of midwives who have knowledge of and experience with intrapartum care. The more homogeneous the group members are with regards to knowledge and experience, the more comfortable they are likely to be in contributing to the discussion and in challenging or contradicting one another, but they may also avoid discussing issues that are uncomfortable for the group (Sim, 1998; Van Teijlingen and Pitchforth, 2007). Morgan (1996) outlines the three basic uses of focus groups: they can be used as a self-contained method, as the principal method of producing data. Secondly, they can be used as a supplementary source of data, in studies where there is a reliance on another primary method – for example, a survey. Finally they can be used in multi-method studies. Morgan (1997:6) defines the use of focus groups as 'a technique that collects data through group interaction, on a topic determined by the researcher's interest. In essence it is the researcher's interest that provides the focus, whereas the data themselves come from the group interaction'.

The main advantage of using a focus group is that it is well suited as a data collection tool in qualitative research, as it is capable of producing a rich dataset, while being flexible and inexpensive. Corbetta (2003) discusses how focus groups can facilitate

revelations *vis-à-vis* motivation and intensity of feelings by comparing different positions about issues that are part of the participants' everyday lives. The main disadvantage of focus groups is that the stronger, more opinionated members of the group may dominate discussions and influence other members. Another disadvantage is that some individuals may not be comfortable in discussing their views and experiences in front of others (Van Teijlingen and Pitchforth, 2007); silence should therefore not be construed, necessarily, as indicating an implied shared view with the more vocal members of the group. Questioning, as performed by the moderator, is required to work out whether or not this is the case (Sim, 1998). However, the advantages of this method outweigh the disadvantages (Streubert and Carpenter, 1999).

Phase two

Participant observation was used in Phase two, as it enabled the researcher to collect information first-hand, based on what people actually do, rather than what they say they do. This allowed me to see and hear how MPs carried out their work and how their role impacted upon other midwives and obstetricians working in the unit. Participant observation entails looking, asking, listening, examining artefacts and recording data (Depoy and Gitlin, 1998). When it is planned systematically and recorded and evaluated for reliability and validity, observation, as a data collection tool, differs from merely looking at what is going on around us. Anthropologists and sociologists, who use this technique to study the interactions and actions of people in their normal social environment, were the first to use observation as a data collection tool, and it has been used as a data collection method in midwifery research by Kirkham (1989), Hunt and Symonds (1995) and Davies (1996), to investigate a range of issues such as midwives and information-giving, the social implications of midwifery and student midwives' perceptions of midwives. Observation has been chosen as a data collection tool in the current study, as it allows for a consideration of complicated situations such as MPs working in a maternity unit setting.

Polit and Hungler (1997:464) describe participant observation as 'a method of collecting data through the observation of a group or organisation in which the researcher participates as a member.' As the researcher has such a visible role in the research setting during participant observation, her or his impact and role needed to be

carefully considered (see sections 1.9 and 3.6). As the researcher cannot observe every aspect of a situation, the focus of the observation needs to be well defined. The issues that need to be considered in participant observation include the physical setting; the participants; the activities observed, along with their frequency and duration; the process; and the outcome (Polit and Hungler, 1997). In participant observation, the researcher should stand back from familiar situations and establish a sense of 'cultural strangeness', to see the situation as an outsider would, while avoiding the pitfalls of 'going native' and not seeing behaviour and activities as being noteworthy (Morse and Field, 1998). Observer bias, where the researcher may discard or not even consider issues that do not fit with their views, also needs to be considered. However, it is recognised that the researcher in this study (as a midwife and a manager) would not be able to see events as an 'outsider' would; nonetheless, efforts were made to try and acknowledge this during data collection and analysis (see sections 1.9 and 3.6). In Phase two, I spent sufficient time in the setting to become established and accepted as a researcher rather than as a manager or midwife. It is acknowledged that two weeks participant observation was a very short time to spend collecting data. Although, I knew the participants and the maternity unit, which allowed me to fit into the research setting quickly, this may well have had an effect on the research findings. The amount of time spent undertaking activities to 'fit in' must be balanced with the time needed for data collection. The clothes worn by the researcher during the period of observation also needs to be considered, to ensure the researcher blends in and is accepted by others in the research setting (Davies, 1996).

Data can be recorded by using field notes and tape recordings. Observational notes are used to describe conversations and events, and theoretical notes are used to attempt an understanding of the meaning of events, methodological notes are reminders for future observations, and personal notes describe the researcher's feelings. Field notes can be taken at the time of the observation or prepared later, to avoid drawing attention to the researcher (Polit and Hungler, 1997). Hunt and Symonds (1995) suggest taking some notes, such as headings and key phrases, openly in the research setting, but taking more detailed notes surreptitiously and recording full details at the end of the day.

The advantages of using participant observation are that it allows an accurate assessment of a situation and provides information that cannot be gathered through interviews alone, all while allowing the flexibility to change the focus of attention. There are, however, a number of disadvantages to using observation, which should be considered. Participant observation relies heavily on the researcher's interpersonal skills, to ensure they are accepted in the research setting. Participant observation is also time-consuming and therefore expensive. The researcher needs to be aware of the risk of spending more time with people they personally like, while avoiding those they dislike. This can also apply to participants, some of whom will feel comfortable around the researcher, while others will be less inclined to contribute (Streubert and Carpenter, 1999).

Participant observation should be overt, to allow participants to make informed choices about participating in research. Overt participant observation can, however, result in the problem of reactivity, where participants may change their normal reactions and behaviour, resulting in an inaccurate portrayal of the situation. The validity and reliability of this method can be improved by spreading the observation period over a longer period of time, to allow participants to become used to the presence of the researcher and return to their normal behaviour. However, this was not possible due to time constraints. Prolonged periods of observation can, however, result in 'observer drift', where the researcher loses concentration and awareness of the situation (Morse and Field, 1998). Furthermore, the researcher also used semi-structured interviews and diaries, completed by the MPs, to gather data.

Phase three

Semi-structured interviews are used to elicit data from participants, in order to explore their everyday experiences. No assumptions are made about the data, which are used to look for emerging themes. Semi-structured interviews were used to further explore the role of MP and its impact on the midwives and obstetricians in the maternity unit, building upon and confirming or refuting what I had seen and heard during Phases one and two. Interviews are valuable data collection tools in midwifery, as they make use of midwives' skills in collecting information through the natural form of social conversation, which is a sensitive and familiar way of gaining information. Researchers from a midwifery background have a privileged position when

interviewing clients, as there tends to be a familiarity and openness that comes from a shared understanding of health, and trust inherent in the midwife/client relationship (Gardner, 1996; Pearson *et al.*, 2000). Rees (1997) states that interviews also allow a woman-centred approach to be used, which enables women to tell their stories in their own words, without restrictions.

In ethnographic interviews, the researcher aims to understand the culture by talking with insiders (Depoy and Gitlin, 1998). Semi-structured interviews are commonly used in qualitative research to explore perceptions, attitudes and experiences. Interviews can be used as the sole data collection method or can be combined with other methods. Semi-structured interview schedules use a series of open-ended questions about the topic area, while allowing various other themes to emerge. Meticulous records of interviews should be made and the process of analysis should be documented to ensure that another researcher will be able to review the process (Harvey-Jordan and Long, 2001).

Kvale (1996) comments that the interview can be seen from two perspectives. From the first perspective, it is a neutral process allowing the researcher to identify objective truths from respondents, in order to capture the reality of the issue being investigated. From the second perspective, the interview is seen as interpretative, where the interview is an interaction between the researcher and the participant. Kvale suggests that the interview is the site for the construction of knowledge. Wetherell *et al.* (2001) describe the interview as a medium in which meaning is created, and Northway (2000) comments that the weight positivists assign to objectivity has resulted in researchers writing themselves out of the data, to avoid contamination. However, in qualitative approaches, the researcher cannot be meaningfully separated from the research. Lamb and Huttlinger (1989) argue that reflexivity is a basic feature of social research and should be made explicit (see sections 1.9 and 3.6).

During interviews conversations are purposeful, therefore, adequate preparation for undertaking interviews is important. The interviewer and interviewee should have a common vocabulary, which may necessitate the use of slang and distinctive terms (Polit and Hungler, 1997). In this study medical jargon was used when interviewing health care professionals, but avoided when interviewing clients. The setting of the

interviews is important, as the environment should be comfortable and relaxing, with disturbances kept to a minimum (Streubert and Carpenter, 1999). The appearance of the interviewer should be nondescript to prevent distractions, and indicators of beliefs or social status should be avoided. Finally, the length of the interview should be agreed upon in advance, so that the interviewee will not worry about the interview affecting later plans (Rees, 1997).

The method of recording the interview has an impact on the success of data-gathering. Tape recordings may fail or be subject to background noise and can also be intimidating; however, interviewees tend to forget about this as the interview progresses. The advantages of tape recording are that it allows for the recording of all information and enables the interviewer to listen to the interviewee and maintain eye contact. Interviews can be recorded by taking notes, but this can be distracting and does not allow for the recording of all information. If the interviewer is taking notes, they may not be able to concentrate on the conversation and this perceived lack of interest may affect the quality of data gathered (Polit and Hungler, 1997; Rees, 1997).

Sometimes the interviewer and/or the interviewee can become intimidated or over-awed by the situation; Morse and Field (1996) describe this as 'stage fright'. If the interview is not producing adequate information, Moser and Kalton (1971) recommend the techniques of repeating part of the question or answer and using an expectant pause or gaze. Rees (1997) recommends that interviewers can improve their chances of gaining good data by using non-verbal means. This can be achieved by sitting to the side of the interviewee, but avoiding any invasion of their personal space, by making eye contact and looking relaxed, and maintaining an open posture, leaning forward and using active listening.

The advantages of using semi-structured interviews are that they allow for the discovery of the problems and basic issues in relation to the subject under study, along with the range of opinions about these. They allow good-quality, in-depth data to be generated, and response rates tend to be high. Responses can be easily gathered from a wide range of people, including those – such as new mothers – who have little time to spare. The interviewer can clarify responses, reduce misunderstandings and

capture additional information, such as any detected magnitude of feeling or understanding (Polit and Hungler, 1997; Rees, 1997).

However, there are some disadvantages inherent in this method of data collection. The possibility of introducing bias and error is high, due to the personal nature of interviewing. This can occur at all stages of the interview process, from planning to interpretation. The researcher has a great deal of influence over both the participants and the information selected; the personality of the researcher can therefore affect the validity and reliability of the study's findings. In this study, as the researcher is a midwifery manager, the participants may have felt inclined to give responses that they thought would show them in a good light. The interviewer also has to rely on the interviewees being honest in their responses. Interviewing thus requires a high level of skill and is both time-consuming and costly (Polit and Hungler, 1997; Rees, 1997). Another weakness of using semi-structured interviews as a data collection tool is that they can only provide the views of a particular respondent at a particular time. If the interview was to be repeated at a later date different responses may be generated.

3.3 Ethical considerations

When humans are used as participants in research, their human rights must be protected. Rees (1997) outlines the three basic ethical principles that should be considered when undertaking research. These are respect for persons, beneficence and justice. There are a number of internationally accepted codes of ethics that govern the conduct of research, to guide the researcher and protect participants. The Nuremberg Code was devised in 1947 in response to experiments carried out by the German National Socialist regime during the Second World War; it comprises 10 principles, with the main one being informed consent. The Declaration of Helsinki was developed in 1964 and revised in 1975, with clauses to protect human rights and makes the distinction between therapeutic and non-therapeutic research. The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research issued the Belmont Report in 1978, and it defines the principles of bioethics as non-malfeasance, beneficence, justice and autonomy.

Research involving human subjects must be overseen by ethics committees, who evaluate whether research will adversely affect participants. Multi-Centre Research Ethics Committees are responsible for considering multi-centre research, where this is conducted within five or more geographical boundaries. Local Research Ethics Committees were established by the DoH in 1991, to standardise the functioning of ethics committees; their collective role is to review the ethical implications of research involving human subjects (Polit and Hungler, 1999). The current study was reviewed by the School of Care Science Ethics Committee at the University of Glamorgan and the Multi-Centre Research Ethics Committee for Wales (see Appendix 5). The relevant Local Research Ethics Committees were informed that the study had Multi-Centre Research Ethics Committee approval.

Improving Health in Wales (NAW, 2001a) outlines the requirements for the standard of research and development undertaken in Wales. *The Research Governance Framework for Health and Social Care in Wales* (NAW, 2001b) ensures that research is well planned, well designed, well conducted and makes a contribution to improving services. The responsibilities of all concerned with research, including employing organisations, are outlined in that document. As a result of these documents, all research undertaken within NHS Trusts has to be reviewed and registered with their Research Risk Review Committees. This study was registered with the relevant committees of the Trusts where the research was carried out.

Access was gained to the units where the study was conducted by requesting the approval of the midwifery managers for Phase one and the Director of Nursing for Phases two and three. Information sheets and consent forms were given to all participants, at a time when they were able to provide informed consent and their written consent could be obtained (see Appendices 6 and 7). Participants were not identified in any way in written documents resulting from this study, and they were not obliged to disclose information that they otherwise preferred to keep private. The Trusts were anonymised in all papers written from the data collected. Tape recordings of interviews will be destroyed after the thesis and any of the revisions thereof have been accepted.

A number of ethical concerns were identified and measures were taken to deal with these issues. The balance between the theory and practical aspects of undertaking research has to be acknowledged, as the most thorough plans can be influenced by practical considerations when undertaking research in a real-life setting (McDonnell *et al.*, 2000). In this case gaining access for Phase two of the study proved difficult. As three MPs were employed in the unit where the researcher works, it was decided to undertake the fieldwork there, for Phases two and three. However, it is acknowledged that conducting the research study in the unit where the researcher was employed as a midwifery manager necessitated a careful consideration of the issue of informed consent.

Obtaining informed consent in qualitative studies is acknowledged as sometimes being difficult (Eisner, 1991), as events in the field may result in changes to plans and unanticipated developments. LaRossa *et al.* (1981) identifies issues in researching families, which are relevant to this study, as the researcher is a member of a midwifery workforce where there are close working relationships. As Phases two and three of this study were conducted in the researcher's own workplace, this may have resulted in the researcher being seen as a colleague or manager, rather than as a researcher. It may have influenced the participants' decision to take part in the study and may have also influenced their level of disclosure. As Van Teijlingen and Cheyne (2004) comment, coercion must not be used to gain consent, especially when dealing with people such as colleagues. Power dynamics must be acknowledged and participants should be reassured that while they are being asked to participate in the research study, they are under no pressure to participate (Collins, 1991; Delgado Bernal, 1998; Johnson-Bailey, 1999) (see sections 1.9 and 3.6).

Therefore, a flexible approach to consent was developed, where the researcher or link midwives (see glossary of terms, Appendix 1) recruited participants for the study and an agreement was gained by informed and process consent, as recommended by Behi (1995). Members of staff were assured that their participation was entirely voluntary and that they were free to withdraw at any time, without it affecting their conditions of employment. Participants were given information sheets to consider and their written consent was sought at a later date. Their verbal consent was then renegotiated

and confirmed throughout the fieldwork. The busy aspect of their clinical work was also considered when conducting the fieldwork.

The fact that the MPs were being observed may have implied to clients that their competency was in question. It was made clear in the information leaflet that the MP role has been audited and found to be both safe and effective. There was a small risk that childbearing women might experience possible harm to their mental health by discussing their experience of childbirth; if this occurred, they were given the opportunity to discuss any issues in confidence with their midwife (see Appendix 6).

The midwives present during the observation period may have felt the need to alter their practice, as the researcher is employed as a midwifery manager and a Supervisor of Midwives. Reassurance was given that the study was not intended to judge their standard of practice. However, if the researcher saw any unsafe practice, she would be ethically obligated to deal with it through appropriate channels. If midwives were concerned about this, they were able to speak to their Supervisor of Midwives (see Appendix 6). The researcher offered her supervisees an alternative supervisor for the duration of the study, but this offer was not taken up. Oliver (2003) discusses the dilemma of researchers wanting to intervene in situations that they perceive as being unfair or incorrect. The researcher decided prior to commencing the fieldwork that intervention would take place only if an unsafe practice was observed and the decision was made just to note events and the researcher's reaction to them.

3.4 Sample and recruitment

Selecting the sample

In qualitative research, the rules for sampling are different than in quantitative research. Qualitative research aims to understand a situation from the personal experiences of the people involved, by encouraging participants to express their views in their own words. Sampling in qualitative research aims to gather information from people who have information about and experience with the subject under consideration (Rees, 1997). The aim of qualitative research is not to gather participants from a representative sample to ensure generalisations can be made,

because in qualitative research, the sample does not represent the larger population (Holloway and Wheeler, 1996).

An ethnographic study focuses on a group of people with something in common (Boyle, 1994), so a purposive sample was recruited for this study. In purposive sampling, the researcher includes individuals or informants on the basis of their relevance, in that they must have the knowledge and experiences sought by the researcher (Lincoln and Guba, 1985). Informants are selected who have experience with the identified cultural group and who are prepared to share this knowledge with the researcher (Speziale and Carpenter, 2003). Morse and Field (1998) list the two principles of qualitative sampling as appropriateness and adequacy. 'Appropriateness' is defined as using participants who can best provide the required information, while 'adequacy' is the ability to provide rich data on the subject under study. The inclusion criteria included staff and clients who had relevant experience of midwifery practice during the intrapartum period and/or the role of MPs. Exclusion criteria included women who had delivered stillborn infants or whose babies had died, women under the age of 16 years and women who did not speak English as a first language.

The strategy for sampling needs to be systematic and explicit, in order to ensure participants are representative of the groups being studied (Holloway and Todres, 2006). In this study I used a sampling strategy to select informants from groups who could provide information about the role of the midwife and MP. I chose to include representatives from midwives, MPs, clients and obstetricians, who had the necessary experience and/or knowledge. The key informants in this study were the MPs who had current and first hand experience of this role. There are approximately 750 midwives working in Mid and South Wales, who had the necessary knowledge and experience, who could have been invited to participate in Phase one of the study. However, the sampling strategy was dependent upon the link midwives to recruit participants. It is therefore difficult to calculate the percentage of available midwives who accepted the invitation to participate.

The number of MPs recruited for Phase two was small, as there were only three MPs working in the maternity unit where Phases two and three were undertaken. There were approximately 74 midwives available to participate in Phase three. The first ten

asked agreed to participate, it is acknowledged that the researcher's employment as a manager may have influenced this, though a flexible approach to consent was developed, where agreement was gained by informed and process consent (see section 3.3). The maternity unit has approximately 110 births per month, so there were a large number of women available for interview. However, like the midwives the first ten who were asked agreed to participate in the study. There were seventeen obstetricians employed in the unit at the time, the first ten of whom initially agreed to participate, however, clinical commitments and some later reluctance on their part resulted in only seven being interviewed. Data collection continued until saturation was achieved, if this had not been the case with the number of participants interviewed, further recruitment would have been arranged.

In Phase one, seven focus groups were undertaken with five to 10 practising midwives in each group, from four NHS Trusts in Mid and South Wales. The link midwives in the units selected midwives from a wide range of ages, grades, locations and lengths of clinical experience. The clinical experience of the participants ranged from newly qualified midwives to those with over 30 years' experience. In Phase two participant observation took place in a maternity unit in an urban setting and involved the three MPs employed there, other staff on duty at the time and the clients for whom the MPs provided care during the period of participant observation. In Phase three, semi-structured interviews were carried out with midwives (n=10) and obstetricians (n=7). The health care participants represented a wide range of ages, grades and clinical experience. Postnatal women (n=10) who were cared for by the MPs were recruited and these interviews were undertaken between two days and six weeks following delivery (see Table Two).

Table Two: Details of participants

Phases of study	**Type of data collection**	**Number of participants**
Phase One	Seven focus groups	Midwives (n=48) with 5–10 in each group
Phase Two	Two weeks of participant observation	MPs (n=3)
Phase Three	Twenty-seven semi-structured interviews	Obstetricians (n=7) Midwives (n=10) Clients (n=10)

Recruitment

Link midwives were nominated in participating units, to work with the researcher to make recruitment arrangements. Prospective participants were given information sheets (see Appendix 6) and written consent (see Appendix 7) was obtained from those who agreed to take part in the study.

In Phase one, the link midwife gave the midwives information sheets and consent forms and invited them to take part in the study. This was repeated until the required numbers of midwives – a minimum of five and a maximum of 10 in each group – were recruited. In Phase two of the study, the link midwives liaised with the researcher to distribute information sheets and consent forms to clients who were due to have their babies during the time the researcher was planning to collect data. These were given out in the antenatal clinic and clients were asked to return the consent forms at their next clinic appointment or to their named midwife, if they wished to be involved in the study. The researcher approached the three MPs and distributed the information sheets and consent forms, and they agreed to take part in the study by returning the consent form to the researcher. Other staff in the unit, who were likely to be on duty when the researcher was present, received information about the study and were asked to consent to having the researcher present when they were providing care.

In Phase three, link midwives and the researcher identified women who had received care from the MPs; these clients were given information sheets and consent forms prior to discharge home from hospital. This process continued until the required numbers of women were recruited. If women agreed to be involved in the study, they were asked to return the consent form to the researcher. Midwives and obstetricians of various grades, who worked with the MPs, were given information sheets and consent forms by the researcher or link midwife and asked to return the executed consent form to the researcher, if they agreed to take part in the study. This process continued until an adequate number of participants were recruited. The interviews with the women were carried out either in a private area in the maternity unit or in their homes. All staff interviews were conducted in a private area in the maternity unit.

3.5 Data collection

Phase one of the study used focus groups to describe how midwives perceive their role in the provision of intrapartum care and to ascertain their view about the MP role. Information from this phase of the study was used to inform the participant observation undertaken during Phase two. During Phase two, the MPs completed diaries and semi-structured interviews were undertaken using an interview schedule, which was developed from issues noted during the initial observations. The aim of this was to clarify and confirm issues noted during previous observations. During Phase three, semi-structured interviews were undertaken with clients, midwives and obstetricians who had contact with the MPs. The interviews were also used to further explore issues raised during the first two phases of the study.

3.5.1 Pilot study

Frankland and Bloor (1999:154) state that in qualitative research, pilot studies provide 'a clear definition of the focus of the study'. The main advantages of pilot studies are that they provide an indication of weaknesses in the project, and may show that data collection instruments are inappropriate – or that the planned study is too complicated or expensive. For this research, pilot studies were undertaken for Phases one and three.

Before commencing Phase one, a pilot study was undertaken by conducting two focus groups. The first focus group comprised eight student midwives from a university in Wales, and the second group, five midwives from an NHS Trust in South Wales. The duration of the first group was one hour, while the second was two hours. This allowed the researcher to gain experience and skills in moderating focus groups. The reliability of the topic guide was also assessed and refined. In addition, the pilot study highlighted the importance of correctly positioning the tape recorder. For Phase three a pilot study was undertaken with two midwives, to test the interview schedule and ensure that it was worded clearly and avoided bias and that its questions would be easily understood.

In qualitative research, data collection is progressive – that is, the data collection becomes better as the researcher improves his or her skills (Harvey-Jordan and Long, 2001). There can, however, be disadvantages to using pilot studies. These include the risk of making predictions that are inaccurate, based on the findings of a small pilot. Another potential concern is that although it is common in qualitative research to include pilot study data in the main study, there is a risk of contamination. This can occur when modifications are made to data collection tools after the pilot study, and when participants have already been involved in the pilot and may respond differently to other participants who were not previously involved (Hundley and Van Teijlingen, 2002). For these reasons, data from the pilot study were not included in the main study.

3.5.2 Phase one – Focus groups

The midwives who attended the focus groups had a range of experience, from the newly qualified to midwives with over 30 years' experience. A total of 48 midwives participated in this phase of the study (see section 4.2). The Trusts were chosen, as they highlight both the variations in client population and the various types of provision of maternity services across Wales (see Table Three). The focus groups were held between May and August 2004, inclusive.

Prior to the commencement of the groups, the midwives present were asked to re-read the information sheet, which included an outline of the subject to be discussed and the duration of the session, and sign the consent form if they were happy to participate. They were also asked to wear name labels. An explanation about the focus group was given and the issue of confidentiality was stressed. The midwives were informed that the focus group would be tape-recorded and the role of the note-taker was explained; all present agreed to the use of both. As Van Teijlingen and Pitchforth (2007) point out, the role of the note-taker is important, given that non-verbal responses and interactions can assist with the analysis of the data. In the reporting of findings, all names were changed to ensure confidentiality; numbers were used to identify the groups.

Private rooms within the hospitals were used, where interruptions could be avoided, and each group session lasted approximately two hours. The researcher undertook the role of moderator and a co-researcher made written notes during the groups. The role of the moderator is to provide adequate information for participants to understand the purpose and direction of the group. The moderator used a topic guide (see Appendix 8) to direct discussions, solicit the group's opinions, encourage the flow of discussion, and ensure that all participants could make a contribution to discussions (McLafferty, 2004; Van Teijlingen and Pitchforth, 2007). Group interactions are perhaps the most important aspect of focus groups, and group norms and cultural values are shared as a result of participants' common knowledge and experience. The participants reflect on a series of questions, and they have the opportunity to hear other responses and make additional comments as the focus group progresses.

Table Three: Details of focus groups

Focus group	Dates	Location	Midwives	Number of midwives
Group 1	7th May 2004	Birth Centre	Midwifery Led - Care Midwives	(n=5)
Group 2	28th May 2004	Birth Centre	Midwifery Led - Care Midwives	(n=5)
Group 3	10th June 2004	Community Hospital	Midwifery Team Leaders	(n=9)
Group 4	14th June 2004	District General Hospital	Hospital and Community Midwives	(n=10)
Group 5	9th July 2004	Community Hospital	Community Midwives	(n=6)
Group 6	21st July 2004	District General Hospital	Hospital and Team Midwives	(n=6)
Group 7	6th August 2004	District General Hospital	Hospital and Community Midwives	(n=7)

Interpretation of the data necessitates checking the distinction between what participants feel is important and what they find interesting. It is easy to assume that if a topic is discussed at length, then it is important, when in fact it may simply be a subject that the participants find interesting. For example, Morgan and Spanish (1985) found that stress was discussed as a risk factor to health more than smoking was, but

this did not signify that it was a more important risk factor. In assessing the importance of issues discussed, the researcher should consider how many groups mentioned it, how many individuals within the groups mentioned it and how much enthusiasm it generated in participants; this can be identified through nodding and agreement. Morgan (1997:63) describes this as 'group-to-group validation'.

However, if the researcher wants to know what participants regard as important, they should ask; Morgan (1997) suggests that this question needs to be built into the data collection tool. In this study, when participants were asked about the functions of midwives in providing intrapartum care, the discussion covered a range of subjects; however, when asked what the most important functions were, they indicated subjects that they had not spent a great deal of time discussing. It appeared that issues such as ensuring the safety of mothers and babies were accepted unquestioningly, and so the midwives did not see any benefit in discussing these in great detail. While other issues – such as providing support for birth partners – were seen as issues that were sometimes frustrating and difficult to deal with, and the midwives enjoyed discussing their shared concerns and methods of dealing with them.

As the researcher was employed as a midwifery manager, the issue of power and influence over the groups had to be considered. Throughout the focus groups I was honest about my role, and my views and feelings about the groups were documented (see section 4.2). Although this could be seen as a disadvantage it did not appear to have a negative effect on the discussions. This may have resulted from the fact that the midwives in the groups knew each other well and their sense of belonging may have given them the confidence to express their views frankly. However, the possible effect of the researcher upon the resultant data is acknowledged (see sections 1.9 and 3.6).

3.5.3 Phase two – Participant observation

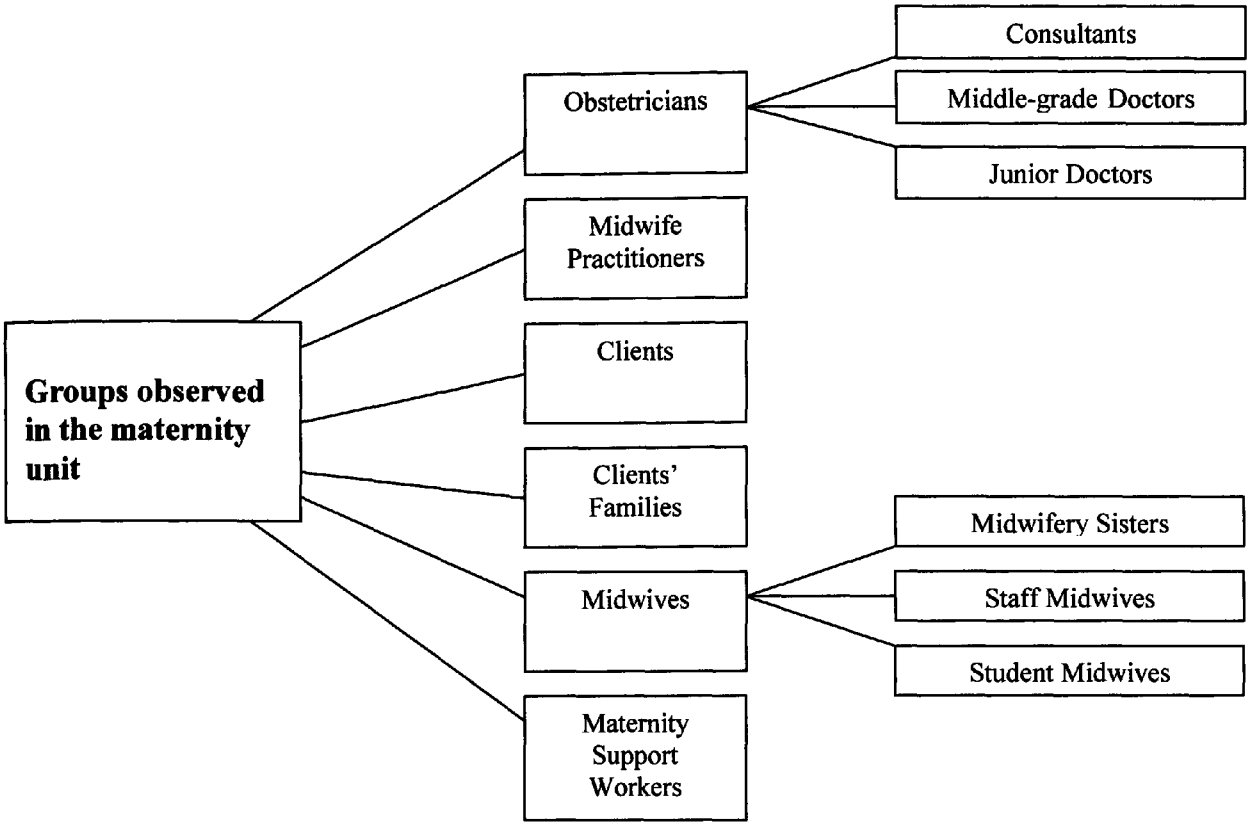
Phases two and three of this study took place in the maternity unit of an NHS Trust in South Wales. This Trust was established in 1996 and serves an urban population of approximately 150,000, with an annual birth rate of approximately 1,500 (information

obtained from local birth statistics). The population is amongst the most severely deprived in Wales, it has some of the highest levels of material deprivation, the lowest educational standards and the poorest quality housing in Wales. During the time this research was undertaken the maternity unit employed seventy-four midwives and seventeen obstetricians (see section 5.2).

Information from Phase one of the study was used to inform the participant observation undertaken during Phase two, which employed a focused ethnographic approach to gather and analyse data from a cultural insider's perspective (Graff and Roberts *et al.*, 1999). The type of participant observation undertaken was 'observer as participant'. In this situation, the main activity of the researcher is to observe and interact; however, to 'fit in', the researcher engaged in some of the activities of the participants (Streubert and Carpenter, 1999). When undertaking ethnographic fieldwork, it is impossible to investigate one group in isolation; if the culture is to be understood, then all participants in the cultural setting need to be considered (Streubert and Carpenter, 1999). When exploring the culture where the three MPs were employed, other people were observed and the impact of MPs on these groups was noted (see Figure One).

Participant observation was combined with document analysis, diaries, and semi-structured interviews with MPs. The MPs were asked to complete a daily log outlining their experiences in the previous shift worked. The use of diaries allows respondents to highlight the issues that are important to them and to describe them in their own words (Polit and Hungler, 1997). The MPs seemed self-conscious about completing the diaries and they were completed for only six sessions out of a possible 14. The interviews were undertaken with MPs using an interview schedule (see Appendix 8), which was developed to clarify and confirm issues noted during the initial observations. If clients who were present in the maternity unit during the period of observation so consented, their case notes were examined to clarify the details of the care they received, and to gain an understanding of their behavioural patterns. These posts cover both maternity and gynaecology services, but in this phase of the study, only interactions between the MP and women who were booked for maternity care were observed.

Figure One: Groups observed in the clinical area



The names of the MPs have been changed to ensure their confidentiality and anonymity were protected. The three MPs observed during Phase two were previously employed in a neighbouring NHS Trust. Sara and Lyn worked as midwifery sisters and Ann worked as a staff midwife; all had had a number of years of experience working as clinical midwives. Data collection for this phase of the study took place during November and December 2004 (see section 5.2 for details of the research setting).

Eight shifts of twelve hours each were worked with MPs over a two-week period, providing a total of 96 hours of observation. It is acknowledged that this was a short space of time in the field, but was unavoidable due to time constraints (see section 3.2.4) The MPs saw 33 clients during this period, although some of these women were seen on more than one occasion (see Table Four). During the observation period, information was gathered during verbal exchanges between the researcher and the MPs, the other midwives and medical staff, and by observing non-verbal behaviour

and the activities of these group members. As a result of the rota, the majority of the time was spent with Ann and Sara and only one shift was worked with Lyn; therefore, her input was limited. Field notes were made during the period of observation and expanded notes were written after each period of observation was completed. A notebook and dictaphone were used to record the field notes (see Appendix 9).

Table Four: Elements of participant observation

Date	MP	Clients seen (n)
20th November 2005	Sara	6
21st November 2005	Sara	1
22nd November 2005	Ann	9
23rd November 2005	Ann	5
2nd December 2005	Lyn	1
3rd December 2005	Sara	6
4th December 2005	Ann	2
5th December 2005	Ann	3

Initially, the researcher tried to see events through a wide lens; hunches, ideas and preliminary interpretations were captured in the field notes, which gradually resulted in observations becoming more focused. Case notes of women in labour were examined to look at referrals and clinical decisions, along with their outcomes. In addition, interviews with MPs were used to check the researcher's understanding and interpretation of the participant observation, in order to strengthen the credibility of the analysis (Lawless, 1992, 1993; DePoy and Gitlin, 1998).

The possible bias regarding the effect the researcher, as a manager in the unit, would have on the setting and the interpretation of what was observed were noted throughout the field notes. However, it seemed that the midwives quickly forgot about the researcher's background, as they became more relaxed and their conversations more informal. Attempts were made by the researcher to use a decision-making or audit trail, as doing so can increase the clarity of a study (Koch, 1994). During data collection, the researcher attempted to describe the reasons behind the decisions that were made, by including them as comments throughout the field notes. This was done by writing details at the beginning of each transcript, of impressions and feelings about the observations, along with any factors that might have influenced the emphasis on different topics. In addition, the researcher kept a journal to note the thought processes behind the decisions made and the researcher's views of events.

However, in ethnographic research, the identification of decision-making trails is problematic, as it is difficult to document all the decisions involved in the conversion of data into theoretical schema, as observations and analysis tend to occur simultaneously and are reconsidered as the study progresses. Decisions are sometimes made existentially and observations are often analysed away from the field; in any case, however, the interpretation should be logical and consistent (Wolf, 1992).

3.5.4 Phase Three - Semi-structured interviews

Data collection for Phase three was informed and influenced by the findings from Phases one and two, which suggested that the MP role was a distinct and separate role, rather than an extension of the midwives' role. Furthermore, the idea emerged from participants that the MP role might possibly have negative consequences for the obstetricians in the maternity unit.

This phase of the study was undertaken between July and December 2005 and took place in the same maternity unit where Phase two was conducted (see section 5.2). The interviews for Phase three of the current study were conducted with midwives (n=10), postnatal clients (n=10) and obstetricians (n=7) (see Table Five). The original plan was to interview 10 obstetricians; however, due to their clinical commitments and some reluctance on their part, it proved difficult to arrange the desired number of interviews within the timescale. The time constraints upon busy clinicians were not fully appreciated prior to the study and necessitated a change to the anticipated number of respondents. The clients were interviewed in the maternity department or in their homes, depending on the time of discharge from hospital. The professionals interviewed were from a variety of grades and had a variety of experience; all of the midwives were female. Recruitment was terminated when no new data emerged.

The length of the interviews varied depending on the participants' responses, but the average interview lasted approximately 30 minutes. The effect of the researcher, as an insider collecting data in an area where she was employed, was considered when undertaking the interviews (see sections 1.9 and 3.6), as a result, some of the participants were asked to check the researcher's interpretation of the data collected.

Table Five: Information about participants in Phase three

Client		Parity
Clients – 3, 5, 6, 7, 8, 9.		Primiparous
Clients – 1, 2, 4, 10.		Multiparous
Midwife		**Current post**
Midwives – 2, 4, 5.		Specialist posts
Midwife – 3.		Management post
Midwives – 1, 6, 10.		Team midwives
Midwives – 7, 8, 9.		Hospital midwives
Obstetrician	**Gender**	**Current post**
Obstetricians – 2, 5.	Female	Junior doctors
Obstetrician – 1.	Male	Middle grade
Obstetricians – 3, 4.	Female	Middle grades
Obstetricians – 6, 7.	Male	Senior Obstetricians

Semi-structured interviews provide an opportunity for all participants to answer the same questions, but within a flexible framework. Separate interview schedules were developed for health care professionals and clients (see Appendix 8), and all participants in each group were asked the same questions, but the ordering of questions was sometimes altered by virtue of their responses (Dearnley, 2005). The aim was to gain an understanding of the culture, through discussions with insiders, in order to discover their perceptions about the role of MP and its impact on midwives and obstetricians in a maternity unit in Wales.

3.6 Reflexivity

Reflexivity can be seen as an honest account by the researcher of how they affected the research process. The researcher has an impact on the research from the very beginning, when the choices of subject and research methods are decided upon. Koch and Harrington (1998) contend that researchers should consider and explain these choices and their reasons for them, as they stem from the researcher's values and predispositions and argue that researchers should include details of their social selves into the research study. It is acknowledged that research findings emerge from particular social contexts and that different researchers are likely to see things in different ways. However, in qualitative research multiple realities have to be accepted; there can never be one true account of events, as the researcher's presence

cannot be eliminated. Qualitative researchers aim to be aware of the impact of their role on the construction of knowledge and attempt to make explicit their effect on the collection and analysis of data, in order to add to the transparency and trustworthiness of their research findings (Finlay, 2002). By doing this they can explain to readers what is happening during the research process, so they can judge whether the findings are believable.

Freshwater and Rolfe (2001) contend that research is always written as if it was conducted in a clear and linear way, even though this is rarely the case. They question the superiority of theoretical research, as opposed to practitioner empirical research, contending that research is an iterative and interactive process, which relies heavily upon the relationship and communication between researcher and participants. They call for a new type of professional, who is immersed in both research and practice. This would provide an insider perspective where the researcher explores their own practice area, rather than the technical rationality of the outsider perspective, where the researcher is said to be objective and unbiased. This, they argue could help bring closer the relationships between academic researchers and practising nurses. They contend that the use of the term bias in research should be replaced by interest, which should be regarded as something positive, as it implies the desire to investigate a phenomenon with the aim of making improvements. Freshwater and Rolfe (2001: 531) identified three types of reflexivity:

- Type I reflexivity is a reflection on the process of reflection, or simply a deeper level and largely introspective meta-reflection.
- Type II reflexivity is a reflection which goes beyond the usual introspective confines to consider the social and political context in which practice takes place, and prompts us to consider the ways in which these might be overcome through praxis.
- Type III reflexivity is practical reflection, or reflection-in-action, in which practice is reflected on and modified as it is happening.

Lipp (2007) asserts that reflexivity is a difficult concept to define, but described it as an approach, which aids the production of knowledge by examining the impact of our

actions and position as we conduct the research. Steier (1991) describes reflexivity as being 'conscious of ourselves,' while Weick (2002) saw it as turning back on oneself. Reflexivity has been described as being a deeper and more complex mode of thought than reflection, while also having a use in research methodology. Reflexivity can also expose vulnerability in the researcher, potentially resulting in it being used in a superficial way (Lipp, 2004).

Researchers inevitably become part of the setting and inevitably have an effect upon it and the idea of an objective reality does not fit well with a qualitative approach to research (Hammersley and Atkinson, 1995). Researcher reflexivity describes the acknowledgement of the effect of the researcher on the research setting. This has a number of elements, which include the impact of the researcher's views, history and biases and how this affects the filtering and interpretation of events. There is also an acceptance of the effect of the researcher on participants' actions and behaviours and an acknowledgment of the result of the research on the researcher. Reflexivity requires that these issues be described in a transparent manner to ensure rigour and validity (Allen, 2003). Emerson, Fretz and Shaw (1995: 216) state:

> When we self-consciously apply the reflexive lens to ourselves it can help us to see and appreciate how our renderings of others' worlds are not and can never be, descriptions from outside those worlds. Rather, they are informed by and constructed in and through relationships with those under study. Hence, in training the reflexive lens on ourselves, we understand our own enterprise in much the same terms that we understand those we study.

There are a number of advantages to using reflexivity, which are outlined by Finlay (2003): Reflexivity allows for the examination of interpersonal dynamics and personal responses to provide useful insights, while allowing for consideration of the perspective and position of the researcher. It can also make the biases and motivations of the researcher's approach and actions transparent. Additionally, it provides a methodological record of decisions made by the researcher and evaluates the research process and outcomes. The use of reflexivity has the potential to:

- Examine the impact of the position, perspective and presence of the researcher.

- Promote rich insights through examining personal responses and interpersonal dynamics.
- Open up unconscious motivations and implicit biases in the researcher's approach.
- Empower others by opening up a more radical consciousness
- Evaluate the research process, method and outcomes.
- Enable public scrutiny of the integrity of the research through offering a methodological log of research decisions.

  (Finlay, 2002: 225)

However, reflexivity carries the risk that researchers can become too preoccupied by their own introspection, which can skew the findings and result in the researcher's voice becoming more prominent than those of participants. There is therefore a need for balance between acknowledging the affect of the researcher and concentrating on the collection and interpretation of data gathered from participants. It is also important for all voices to be heard (Finlay, 2002). Although participant validation was used in my study (see section 3.7), I also attempted to ensure the voices and perspectives of each group were acknowledged, in order to avoid allowing one group's agenda to dominate.

Traditional ethnographies originated from anthropology, which is concerned with the study of unfamiliar cultures; however, more recently ethnography has been used by researchers to study their own culture and there has been an increase in researchers using their insider status when conducting research (Allen, 2003). This has resulted in debates about the advantages and disadvantages of insider and outsider research and the polarization of views as to which is most appropriate. It has been argued that insider status results in more authentic research, as ethnography requires close immersion in the field and a degree of familiarity with participants and the setting. Familiarity also allows for a greater understanding of issues and the ability to read between the lines. While the opposing view argues that outsider status avoids bias resulting from prior knowledge of participants and the research setting, and avoids the risk that some routine behaviours and occurrences could be overlooked. However, outsider status can impact upon the development of trusting relationships with

participants and may restrict their openness with the researcher (Pugh *et al.*, 2000; Bonner and Tolhurst, 2002).

Manias and Streeet (2001b) explored the research dilemmas and practice that emerge from the use of ethnography drawing on their study of nurses and their relationship with doctors and each other in a critical care hospital in Australia, where one of the authors worked. They concluded that though ethnography provides opportunities to consider organisational and social practices and can facilitate dialogue between participants, the central role of the researcher tends to result in the portrayal of participants realities in accordance with the beliefs and biases of the researcher. The use of reflexivity addresses this issue by trying to reveal the subjectivity of the researcher and the power relations within the research process. To achieve this the complexity of social relations and the socially determined position of the researcher within the culture being described needs to be made transparent.

Barton (2008) describes practitioner ethnography as a research approach, which provides the opportunity for practitioners to explore the culture of their workplace, where the researcher is a member of the group being studied. Barton (2008) describes practitioner ethnographers as individuals who are healthcare managers or practitioners who investigate their own workplace. The style of the researcher's interaction during fieldwork is influenced by their role in the research setting, but generally in such cases the researcher integrates and interacts with participants. Traditional ethnographers attempt to integrate into the culture under study; however, their results are likely to be general and indirect, whereas a practitioner ethnographer possesses insider knowledge and insight that can be used when accessing and analysing data. In such cases the use of reflexivity can provide insightful reflection, which can provide useful understanding of the culture. The researcher should consider how their relationships with participants affect their subjectivity and the findings of the study. A degree of self-awareness is necessary for this, as is an understanding of the cultural values of both researcher and participants (Laugharne, 1995)

Barton (2006a; 2006b) undertook practitioner ethnographies into the education of Nurse Practitioners. He outlined this approach, as representing the reflexive dual role of the researcher and member of the research setting. It has been argued that

practitioner ethnographies are superior to other more traditional approaches, which employ a rigid approach to data that results in only a passive link between clinical practice and research (Hammersley and Atkinson, 1995; McLeod, 1999; Shaw, 2002). On the other hand, such reflexive relationships can result in challenges regarding subjectivity and objectivity. In addition, there are challenges involved in balancing the roles of insider and researcher (Barton, 2006a; 2006b).

Reflexivity provides opportunities to examine the limitations of the research methods, which allows for remedial action to be taken or compensated for. In my study two weeks of participation observation was a very brief time to spend in the field and may well have affected the findings, though due to time constraints this was unavoidable. However, the fact that I was an insider who knew the clinical situation and the participants went someway to compensate for this weakness, as did the multiple data collection methods used, which allowed for insight through analysis of multiple perspectives and positions. In my study, I felt it was necessary to combine interviews with participant observation. As the research was being undertaken in the unit where I was also employed as a manager, there was a risk that secondary accounts from midwifery staff could not be fully relied upon to provide trustworthy data. For this reason focus groups were also employed, not only to provide data which allowed the study to be placed in context, but also to obtain a range of views from a number of midwives across South and Mid Wales about the role of MPs.

My role as a manager in the unit undoubtedly had an initial impact on my relationship with participants who probably thought I was there to judge their practice; however, I tried to employ a number of strategies to overcome this. For example, the way one dresses can affect the impressions made on others (Goffman, 1959). In healthcare, uniforms denote rank, occupational group and status, thus the manner in which the researcher dresses impacts upon their acceptance in hospital settings. I therefore decided to wear a theatre scrub suit, as this was the uniform which tended to be worn by both midwifery and medical staff.

In healthcare settings the type of work undertaken denotes status (Allen, 2001b). Involvement in work activity allows acceptance in the setting, especially when the type of work undertaken includes mundane and basic aspects of care. I therefore made

an effort to do this type of work, in order to try and level the perceived difference in status between the staff and myself. Story- telling and conversations are used to define social groups, as they allow for the sharing of experiences and moral standards (Allen, 2001a). In my study I found it relatively easy to use conversations and storytelling as a way of being seen as one of the team who shared a common vocabulary (medical jargon) and shared experiences of incidents which had occurred in the unit and memories of retired staff members. I also shared information about my family and myself and encouraged participants to do the same by expressing an interest in their lives. I also told stories about myself which were self-effacing and confided that I was concerned that I was not as up-to-date with clinical practice as I would have liked and asked for their support and advice. I listened to their stories about current staff, but when they included gossip or derogatory remarks I did not comment or condemn. I was aware that I was being included as part of the team, when staff remained in the sitting room and chatted, rather than dispersing, as they often did when I visited ward areas in my managerial role.

Simmons (2007) reflected on her experience as a manager undertaking her research in her employing organisation into the role of nurse consultants and highlighted some of the issues she had to deal with, such as role and loyalty conflicts. At the time this study was undertaken there were only a small number of nurse consultants and therefore only a few study sites were available; this can often be a problem when researching new roles, as I discovered in my study. Six nurse consultants participated in Simmons' study and data were collected from semi-structured interviews and five days participant observation spread over two years with each consultant. Interviews were also undertaken with stakeholders. As Simmons was a part-time PhD student there were limitations on the amount of time available for data collection. Simmons described herself as an insider, in that she was an insider within the profession of nursing and an insider as an employee of the organisation. However, as she did not undertake clinical work she was also something of an outsider in clinical areas. In my study I was also aware of some conflicts, as I was a manager, clinician and researcher, and sometimes I think staff saw me simultaneously as all of these things, but again this is only my perception. The dynamics of these roles had to be carefully managed in order to position myself as a marginal native.

In Simmons' study there were concerns that participants may have felt obliged to become involved in the research study and although she emphasised that it would not be a problem if they declined, one can never be sure whether they felt pressure to participate. Initially, she felt that she was viewed as a management spy and though she tried to stress her independence, again it is difficult to know how staff actually viewed her. I was aware that staff may have felt pressure to participate in the current study (see section 3.3), and that I might have also been perceived in this way. Simmons acknowledges that existing relationships may also have hindered her attempts to ask probing questions, as a certain knowledge of events was taken for granted. Responses were often short and accompanied by comments such as '*you know what I mean.*' This problem was also highlighted by Manias and Street (2002b) and was managed in both studies by asking more probing questions. I recognised this problem from my study and I explained some of my follow-up questions by saying, 'this may seem daft or obvious, but I need to be sure I understand.'

There was also conflict noted by Simmons when participants made controversial or negative statements about other staff. Again I can relate to this in my study and I also diverted conversations away from this and tried not to agree or disagree with the sentiments, but just to note them. On a more positive note the participants in Simmons's study seemed to enjoy talking about their role and of having the opportunity to reflect upon their practice, which again I recognised from my study, where the MPs appeared to enjoy the discussions we had.

There is also a need to consider the power imbalances between participants and researcher, as they may have for example differing backgrounds or educational levels. Steps need to be taken to acknowledge and limit the effect of this. In my study self-depreciating humour was used to make conversations more acceptable and easy, though it is acknowledged that I tried to ingratiate myself with participants and pretended to be more friendly and outgoing than perhaps I am. Also at no time did I display any irritation with situations I observed, even when I felt things could have been managed differently. My priority was to be accepted as part of the team and to maintain relationships, though I would have intervened had client safety been a concern. Although this approach could be construed as being somewhat insincere, it was necessary to become accepted and ensure participants felt able to confide in me.

One thing that resulted from this during data collection with midwives, was that they told stories, which often portrayed medical staff in a negative way. This may have been because I was more accepted as a part of the midwifery team, as a result of our shared background.

Such negative accounts were not given by the other groups in the study and perhaps if the researcher had been a doctor or user of the service responses may have been markedly different. I suspect that I may have colluded with the midwives to ensure acceptance as part of their team and therefore may have encouraged them to be perhaps more honest, than they might have been with another researcher, in the way they talked about medical staff. It is apparent that the way participants choose to respond is dependent on how they wish to be portrayed and how acceptable they think their responses may be to the researcher. In my study I found myself inadvertently trying to be part of the midwifery team; however, I am still not sure whether I was perceived as a manager, researcher, colleague or midwife.

A frequent criticism of reflexivity is that it results in uncertainty, which can be unsettling; however, reflexivity should not be rejected as a result of this. In qualitative research the impact of the researcher and the resultant subjectivity is accepted. Though this prevents a scientific true account of events being portrayed it accepts the existence of multiple realities (Lipp, 2004).

3.7 Data analysis

Data from each phase of the study were analysed separately. The same system was used for each phase and an analysis was undertaken concurrently with the collection of data. DePoy and Gitlin (1998:136) describe the analysis of ethnographic data as 'moving from description to explanation, to revealing meaning, to [the] generation of theory'. However, in ethnography, the gathering and interpretation of data cannot be separated; ideas emerge during fieldwork and while some of them will be discarded, others will merit further exploration. On completion of the fieldwork, the notes and transcripts can act only as a guide as the researcher considers the totality of the process. Ethnographic analysis 'is not linear, it is messy', and cannot be a routine

process achieved by following instructions, as interpretations are often derived intuitively (Okely, 1994:21).

Triangulation can be described as the use of a number of data sources and collection tools, and is a feature of ethnography (Lincoln and Guba, 1985). It provides a foundation for validity and is rooted in the holistic approach of ethnography, while affording a broad perspective that enhances credibility. The advantages of using triangulation are that it ensures multiple sources of data, which can overcome biases resulting from the use of just a single method. It also provides for multiple investigations within a single study (Koch and Harrington, 1998). The findings from the three phases of this study were brought together and interpreted to uncover the meaning of the themes identified in the study. This requires imagination and intuition in order to identify patterns, motivations and explanations (Richie and Spencer, 1994). Exploring the themes generated from the analysis and developing them into organising concepts (see Appendix 13), which comprise the structure of the discussion chapter, achieved this. This was done in order to address the research aim and describe the culture studied, making it understandable to the reader.

In this study, endeavours were made to ensure accuracy and rigour while interpreting the data, with the aim of ensuring that the experiences of participants were truthfully portrayed. The biases and experiences of the researcher, and their possible effect on the data gathered and the interactions made, were highlighted in the field notes (see Appendix 9). In the current study, findings were verified with participants to ensure they represented the culture (Depoy and Gitlin, 1998; Lawless, 1992, 1993; Pillow and Mayo, 2007). Member checks were used in Phases two and three of the current study to confirm the participants' agreement with the researcher's interpretation and understanding of the cultural scene. In Phase one, the note-taker confirmed her agreement with the interpretation of the data. Such a process strengthens the credibility of the analysis. During analysis where there were negative cases or contradictions between accounts and observations, I considered the context of each and tried to make inferences about the reasons for this, without trying to identify the true version (Hammersley and Atkinson, 1995).

Using an audit trail can increase the truthfulness of a study, as this enables readers to see the reasons and logic behind the decisions made by the researcher during the study (Koch, 1994). In ethnography, the researcher must actively participate in the culture and develop a certain intimacy with members. The term 'researcher as instrument' is used to describe the important role the researcher plays in interpreting and analysing the culture. The effect the researcher has on the results is also analysed, this is referred to as 'reflexive analysis.' Acknowledging the effect of reflexivity in the study, I commented throughout the field notes the possible biases regarding what was observed and the effect that I would have had both on the setting and the interpretation of what was observed. This cannot be avoided, but its influence on both the process of collecting data and on their interpretation should be noted (Kingdon, 2005). It is acknowledged that the coding was affected by the topic guide and interview schedules used, as the background of the researcher had an effect on what were regarded as important issues for discussion. Furthermore, I kept a journal to note the thought processes behind the decisions made and my thoughts and feelings about events.

The current study broadly uses the Framework method of qualitative data analysis outlined by Richie and Spencer (1994), though the analysis for Phase two was less structured. Framework analysis has been used in policy research, which can involve individual interviews, group interviews and observation work and is generally completed within short timescales. It allows the analytical process to be made explicit. It has been used in conducting applied research and has been refined and developed over the years. It can be used when there are conceptual questions such as: What are the perceptions that are held? What is the nature of people's experiences? And what elements operate within a system? Framework analysis can be adapted to suit the specific aims of a study and has proved flexible for a range of different types of studies, including studies involving different groups of participants. It is a suitable method for analysing transcripts, fieldnotes and other written documents. The Framework method facilitates systematic analysis and aims to provide some coherence and structure to such cumbersome data sets, while retaining a hold of the original accounts and observations from which it is derived. The Framework method has a number of interwoven but distinct stages to assist with the 'defining, categorizing, theorizing, explaining, exploring and mapping of data' (Richie and

Spencer, 1994:176), which allows for the reconsideration and reworking of initial ideas.

Familiarisation is the first stage of the framework method of analysis, and it involves the researcher becoming immersed in the data and gaining an overview of their depth and diversity. Reviewing the data and noting ideas and themes that emerge achieves this. In the current study, the researcher transcribed all of the data verbatim, which was then read and re-read to allow for a total immersion in and familiarisation with the data. Phase one data comprised the transcripts of the focus groups, notes taken during the groups and notes of the meetings following each focus group. For Phase two, an ethnographic record of the observation was made, by recording explicit details in field notes and describing the research setting. The transcripts of the interviews and diaries along with the analytic memos were also included. Phase three data was made up of interview transcripts.

The second stage involves identifying a thematic framework; this was achieved by identifying key issues, concepts, and themes into which the data were sifted and sorted. The structure of the thematic framework was influenced by the aim of the study, and by the topic guide and interview schedules used to gather data. The format was also influenced by the subjects raised by participants and by patterns or ideas that were noted during the process of data collection and familiarisation. In the current study, a separate thematic framework was developed for each phase of the study, which identified categories and their relationships.

Indexing is the process whereby data are sifted and sorted. All of the data were read and imported into a computerised data analysis programme (NVivo), which was used to assist with the analysis (Gibbs, 2002). Although computer software can assist with indexing, researchers must use their own interpretations of the significance and meaning of the data. Moreover, when interpreting focus group data from Phase one of the study, consideration was given to how many respondents and groups mentioned an issue, as well as the strength of the feelings exhibited when issues were discussed. A peer review of this stage can allow a researcher to check his or her coding of the data and consider other options. In Phase one the midwife who acted as note-taker during the focus groups independently checked the coding of a sample of the

transcripts. This provided the researcher with the opportunity to discuss coding choices and consider other interpretations of the data. In Phase two, the MPs were asked to check the notes of observations and the interpretations thereof. In Phase three some of the interviewees were asked to comment on the interpretations of the data made by the researcher. In Phases one and three, there was agreement with the researcher's interpretation, though in Phase two initially one of the MPs disagreed with an aspect of the interpretation, saying that they did not have a better working relationship with the obstetricians than the midwives had. However, having considered this, she informed the researcher that she had changed her mind about this issue.

Charting involves the researcher considering each issue or theme. Data were lifted from their original context (transcript) and rearranged into themes. Themes and sub-themes relating to the culture emerged as data collection and analysis progressed, and some of these themes were merged to create a more concise and significant categorisation. This requires abstraction and synthesis and was assisted by the computer software package NVivo. The stages in the process of identifying themes and sub-categories are illustrated in Appendices 10, 11 and 12.

The process of mapping and interpretation is not just a mechanical process; it emerges from the data and the intuition of the researcher. From the data collected, the researcher reviewed the themes, compared and contrasted information, searched for patterns and explanations and put together an overall picture of the phenomena studied. The themes from the three Phases of the study were brought together and explored to develop organising concepts (see Appendix 13), which form the structure of the Discussion Chapter. Finally the analysis was discussed and confirmed with supervisors.

3.8 Limitations of the method

There are a number of limitations concerning the method employed in this study:

Ethnographic research is costly, time consuming and requires well-informed researchers. Risk and how the researcher deals with it is a major issue, as no

participants should be put at risk in order to collect data. Also the researcher must ensure participants have adequate information to make informed decisions about participating. There is also a need to consider the researcher's responsibilities regarding ensuring participants are protected from exploitation (Streubert and Carpenter, 1999) (see section 3.3).

Focused ethnographies can produce valid and coherent knowledge. Nevertheless, there is a risk that the scope of a study may be too narrow and may exclude relevant data, as data collection focuses upon, and is conducted during a short timeframe. In this study it is acknowledged that two weeks participant observation was a very short time to spend collecting data, though time constraints did not allow me to extend this period. Although, I knew the participants and the maternity unit, which allowed me to fit into the research setting quickly, this may well have had an effect on the research findings. Too little data can result in false assumptions, however, too much data can be difficult to process.

The nature of the data collection tools employed in the current study necessitate a close relationship between the researcher and participants. Rees (1997) points out that it is legitimate for the researcher to share personal information with participants when asked; in this way, discussions can be a two-way interaction, ensuring the relationship is kept equal and open. However, in so doing, there is the chance that participants may start to see the researcher as a counsellor. Following the data collection, the researcher should offer opportunities for participants to discuss any resultant issues with a suitable professional (Streubert and Carpenter, 1999) (see Appendix 6).

The limitations of focus groups include the fact that the stronger, more opinionated members of the group can sometimes dominate discussions and influence other members. Also some individuals may not be comfortable in discussing their views and experiences in front of others, therefore silence should not be construed, necessarily, as indicating an implied share of views with the more vocal members of the group. Questioning, as performed by the moderator, is required to work out whether or not this is the case (Sim, 1998; Van Teijlingen and Pitchforth, 2007). A limitation specific to this study was that arranging the focus groups during Phase one was time-consuming, as they had to be arranged at times when activity in the units

allowed midwives to be released; on occasion, this resulted in the focus groups having to be rearranged.

There are a number of limitations of using participant observation for data collection. Firstly, it relies heavily on the researcher's interpersonal skills, to ensure they are accepted in the research setting. Participant observation is also time-consuming and therefore expensive. The researcher needs to be aware of the risk of spending more time with people they personally like, while avoiding those they dislike. This can also apply to participants, some of whom will feel comfortable around the researcher, while others will be less inclined to contribute (Streubert and Carpenter, 1999). Participant observation can result in the problem of reactivity, where participants may change their normal reactions and behaviour, resulting in an inaccurate portrayal of the situation. Enough time needs to be spent in the field to allow participants to accept and feel comfortable having the researcher around. Although the period of participant observation was limited in the current study, participants were used to me working on the unit, which may have gone some way to compensate for this. Prolonged periods of observation also carries the risk of problems, as it can result in 'observer drift', where the researcher loses concentration and awareness of the situation (Morse and Field, 1998). Accessibility proved to be difficult for Phase two and in retrospect I should have considered the powerful position of gatekeepers when undertaking fieldwork and planned strategies to overcome their concerns.

There are some limitations inherent in using interviews as a data collection tool. The possibility of introducing bias and error is high, due to the personal nature of interviewing. This can occur during all stages of the interview process, from planning to interpretation. The researcher has a great deal of influence over the participants and the information selected. Therefore, the personality of the researcher can affect the validity and reliability of the study's findings. The interviewer also has to rely on the interviewees being honest in their responses. In this study, as I am a midwifery manager, the participants may have felt inclined to give responses that they thought would show them in a good light. Interviewing thus requires a high level of skill and is both time-consuming and costly. Another limitation of using interviews as a data collection tool is that they can only provide the views of a particular respondent at a

particular time. If the interview was to be repeated at a later date different responses may be generated. (Polit and Hungler, 1997; Rees, 1997).

Though the findings of Phase one of the study resulted in a dataset that was broader than the mere provision of intrapartum care, it provided a baseline understanding of the current role of the midwife, which allowed the second and third phases of the study to be explored in context. A number of the findings regarding the role of the midwife were similar to those of other studies (Bluff and Holloway, 1994; Kirkham, 1999; Hunter, 2004; Nicholls and Webb, 2006). However, many of the opinions expressed by the midwives were controversial, such as the view that women want to hand over control to midwives during labour. The midwives felt quite comfortable about expressing these views, which may have been because they knew each other and shared the same professional background (Van Teijlingen and Pitchforth, 2007). The fact that the researcher is employed as a midwifery manager might have suppressed the expression of frank opinions, but the power of 'belonging' appeared to override this to give the respondents the opportunity to raise and discuss the issues and frustrations they felt were important in clinical practice (Van Teijlingen and Pitchforth, 2007).

Another limitation of this study was that the researcher was a manager undertaking research in her own workplace. McEvoy (2001) explores the subject of undertaking research in familiar areas and identifies four limitations of having an insider's perspective. Firstly, it is difficult for researchers to question things that are self-evident when they are familiar with the social scene. Secondly, insiders may be unable to maintain a balanced, objective perspective about a social world of which they are members. Thirdly, researchers may not ask questions regarding well-established social mores. Finally, there may be a reluctance to ask a member of a social group about sensitive issues; moreover, as the researcher of the current study was a midwifery manager, participants may have felt inclined to give the type of responses of which they felt the researcher would approve. However, in any study, the Hawthorn effect should be considered, which is the awareness of participants that they are involved in a study, and which may in itself affect the way they behave and respond (Polit and Hungler, 1997).

McEvoy (2001) states that being an insider also has the advantage of allowing the researcher to read between the lines. This issue has been considered by a number of other researchers. Pellatt (2003), for example, undertook an ethnographic study in a spinal cord injury unit, where she had worked for a number of years. Though she acknowledged that her background influenced her reasons for undertaking the research, as well as the ways in which it was conducted and the interpretation of the data, she stated that she was able to use her experiences there to uncover valuable meanings. Though being an insider affects the objectivity of the researcher, it can be managed and acknowledged through a process of reflection and self-awareness (Henstrand, 2006) (see sections 1.9 and 3.6).

During this study I was aware that as a midwifery manager, conducting research in the unit where I worked, there was the potential for an imbalance of power. I made every effort to avoid using my position in a negative way, which could possibly exploit others. I endeavoured to be constantly attuned to how my values and beliefs might have impacted upon my actions and interpretation of events. Conducting the research study in my own unit required careful consideration of the issue of informed consent. Participants were reassured that while they were being asked to take part in the study, they were under no pressure to participate. However, it is acknowledged that this may have influenced their decision to take part in the study and may have also influenced their level of disclosure. In order to overcome this issue a flexible approach to consent was developed, where either myself or the link midwives recruited participants for the study and agreement was gained by informed and process consent (Behi, 1995). All participants were reassured that their participation was completely voluntary and that they were free to withdraw at any time, without it affecting their conditions of employment. Participants were given information sheets to consider and their written consent was sought at a later date. Their verbal consent was then renegotiated and confirmed throughout the fieldwork (see section 3.3).

As a researcher I was part of the research process and inevitably I made choices about which information to exclude and which I felt was important enough to include. However, I tried to be aware and open about my biases and motivations. The midwives and obstetricians present during the observation period may have felt the need to alter their practice when I was around and reassurance was given that the

study was not intended to judge their standard of practice. During data collection, I tried to describe the reasons behind the decisions that were made, by including them as comments throughout the field notes (see Appendix 9).

In ethnography the researcher has a great deal of influence over both the participants and the information selected; the personality of the researcher can therefore affect the validity and reliability of the study. There was therefore a need to consider the issues of power, relationships and reciprocity. In Phase two, it appeared that I was accepted by both staff and the clients, and it was surprisingly easy to 'fit in'. Initially there seemed to be an expectation that I was there to assist or monitor the staff, but this lessened quite quickly as they became more aware of the purpose of the research study. Throughout the period of participant observation I was aware that events were being seen from the perspective of a midwife and a manager, as well as of a researcher. Attempts were made to see things as objectively as possible, but it is acknowledged that this influenced the things noted and recorded, as well as the interpretation of events. Efforts were made to identify clearly which events led to the development of the themes and comments, and they were recorded in the field notes at the end of each shift, which described the researcher's thoughts and interpretations.

It is acknowledged that the analysis was affected by my background, which inevitably had an effect on what were regarded as important issues for consideration. I kept a journal to note the thought processes behind the decisions made and my thoughts and feelings about events. However, it is difficult to document all the decisions involved in the conversion of data into theoretical schema, as observations and analysis have a tendency to occur simultaneously and are reconsidered as the study progresses. Nevertheless, I made a conscious effort to ensure the interpretation was logical and consistent. The effect I had, as an insider undertaking research in the area where I worked was considered during analysis of the data and as a result, some of the participants were asked to check my interpretation. In addition, the interviews with MPs were used to check my understanding and interpretation of data collected during the participant observation (see section 3.7).

Research questions always arise from the researcher, and prior knowledge and experience contribute to the conceptual map of the subject to be studied. Wimpenny

and Cass (2000) suggest that this can limit and reduce the depth of the research. However, to embark on research with no preconceptions is impossible, especially when the researcher is from the same professional group as the participants involved in the study. Hammersley and Atkinson (1995) suggest that the prejudices, values and assumptions of the researcher should be acknowledged and utilised to provide new insights.

The next three chapters present the results of the research study. The results are presented in the form of narrative description, using relevant quotes from participants to emphasise pertinent issues.

CHAPTER FOUR – PHASE ONE RESULTS

Where there is much desire to learn, there of necessity will be much arguing, much writing, many opinions; for opinion in good men is but knowledge in the making. (Milton, 1644, Edited by Sabine, 1986:45)

4.1 Introduction

Phase one of this study employed focus groups and was undertaken first in order to place the findings of the rest of the study in context, as previous research considered midwifery practice in England rather than Wales. It also provided information on midwifery at that specific time. In addition, it provided a basic understanding of how midwives perceive the role of MP. Twelve categories emerged from the data and were grouped under four themes (see Appendix 10 for the table outlining the stages of coding). In this part of the study, there was a sense of *'group-to-group'* validation, as all of the groups had similar reactions to the topics discussed (Morgan, 1997:63). The findings are presented in the form of narrative description and comments from focus groups. The themes that emerged from this Phase highlight midwives' views about the essential aspects of their role and which aspects should not be relinquished; included in this theme are the views of midwives concerning the MP role. The study also identifies midwives' perceptions of how they are perceived, both by colleagues and the public, and their views about their experience of working in the NHS.

4.2 Research settings for Phase one

4.2.1 Details of focus groups

Focus Group 1 - The focus group took place in an established rural birth centre with a high home birth rate. The five midwives who attended provided midwifery led care and appeared to know each other well and were supportive of each other. This allowed them to feel secure enough to share their thoughts and views openly. The midwives seemed to assume that, as I was a midwife, I would be able to understand events and aspects of their world and I had to seek clarification when issues were

being discussed that I did not understand. The midwives' responses were initially reserved, but their answers were well considered. They said that they felt privileged to work in such an environment where they had the time and freedom to give the type of care they felt women needed. They commented that other staff felt that they were not as 'switched-on' or knowledgeable as their hospital colleagues. Although there was a degree of resentment about this, they stated that they felt that they had a great deal of knowledge and expertise concerning midwifery care.

Focus Group 2 - The focus group took place in a recently established birth centre. The five midwives who attended the meeting provided midwifery led care, were part of the same team and appeared to know each other well. The midwives were 'fired-up' by their recent success in establishing the birth centre and very enthusiastic about midwifery care. There was an assumption that because both the researcher and note-taker had been through the same experience of setting up a birth centre that there was a shared understanding of the difficulties of challenging the established ways of delivering care. Thus they believed that details and views did not have to be fully explained but there were times when they assumed that I would understand their shared experience when I did not, and an explanation had to be requested. They said that they felt they occupied a privileged position, in that they were able to provide the type of care they believed in and work in an environment where they were supported by each other, away from any interference (they implied this meant managers and medical staff). They commented that they felt sympathy for midwives who worked in consultant-led units who were not able to practise autonomously, but acknowledged that not all of the midwives who worked there would want to work as midwifery-led midwives.

Focus Group 3 - The focus group was held in a community hospital. The nine midwives who attended were community team leaders from a large NHS Trust. They were the same grade as the other midwives in their teams, but had different job descriptions and were responsible for managing a team. Their teams covered all of the geographical areas of the Trust, which included urban, rural and metropolitan areas. These midwives met regularly together and the focus group took place at the time of one of their meetings. The manager stayed for the focus group, with the midwives agreement and this did not appear to affect their responses, perhaps because they also

saw themselves as having responsibility for managing staff. As I am employed as a midwifery manager this helped me to be accepted and to generate frank responses. The atmosphere was friendly and all present obviously knew each other well and expressed their views candidly and honestly.

The midwives gave a balanced view of midwifery practice and were enthusiastic about the care they provided. They did, however, acknowledge the difficulties in the provision of midwifery care within the NHS and the changing demands resulting from healthcare policy recommendations. Like group one, they commented on the negative view held by hospital midwives about the community team midwives. It was felt there was a need for a balance between the provision of hospital and community care and that both were important. They also expressed the view that their knowledge and expertise could benefit the hospital midwives, but felt that this help was not always welcome. They were critical of the way that maternity services were managed and the pressures midwives had to work under. It was felt that these pressures came from government policy initiatives, senior midwifery management and medical staff and they commented that these pressures were unreasonable and unnecessary. I was reassured that they felt able to express these views, considering my role within maternity services.

Focus Group 4 - The focus group took place in a busy maternity unit in a metropolitan District General Hospital. The ten midwives who attended the group were from various wards and departments within the unit and the community setting. Although they all knew each other they did not appear to work closely together and some obvious tension and rivalry between different areas was apparent. The supportive atmosphere noted in the birth centres was not apparent here, and the views of the midwives in the birth centres about the pressures under which the hospital midwives had to work, was confirmed. These midwives had the same basic views about midwifery care but appeared to be far more affected by the pressures and demands of working in a busy unit and the accompanying difficulties of working with doctors who, they felt, added to the pressures they experienced. Again dissatisfaction with midwifery managers was noted.

Focus Group 5 – The fifth focus group was held with six community midwives who rotated in and out of a busy maternity unit in a metropolitan hospital. The atmosphere was fraught, with two of the midwives stating that they were always roped into 'such things,' while the hospital staff were not. They expressed the view that they were as busy as the hospital staff, but this was never recognised. However, when given the opportunity to leave they decided to stay. They gave the impression that they stayed in order to express their dissatisfaction with their working lives. The other midwives present did not appear to share their views but some dissatisfaction was evident with them all. The conflict between hospital and community staff was obvious in this group, with the view forcefully expressed that the hospital midwives felt that they were superior. Although the midwives knew each other well, there was little evidence of camaraderie or support between them. The midwives in this group provided very frank responses.

Focus Group 6 - The sixth focus group was held in a maternity unit in a District General Hospital, which covers both rural and urban areas. The six midwives who attended all knew each other well and the relationships were friendly and close. The group was made up of a mixture of hospital and group practice midwives. They all appeared happy and shared a good sense of humour, their responses were well considered and insightful. There did not appear to be a great deal of conflict in the unit, although the issue of team midwives, who provided integrated hospital and community care, 'coming-in' to the labour ward was said to be difficult at times.

Focus Group 7 - The seventh focus group was carried out in a District General Hospital, maternity unit in an urban area. The focus group took place after two attempts to arrange it had failed with staffing problems being given as the reason. During informal discussions while attempting to arrange the focus group, the staff seemed keen to demonstrate how busy and short of staff they were. This view may have resulted from the fact that a change of management was occurring in the unit which appeared to affect the organisation of services and added to the pressures felt by the midwives. The group took place in a delivery room, as the midwives stated that they were too busy to leave the labour ward, and the midwives sat around the delivery bed, as there were apparently no other areas available. Seven midwives attended but one had to leave early. Some of the midwives present were from the hospital and

some from the community. The midwives gave thoughtful answers, but the conversation often returned to their own unit and their lack of job satisfaction. The recently appointed manager was present, with the agreement of the midwives, and I felt at times that the midwives used the focus group to express their grievances. It was apparent that the experience was uncomfortable for her. The fact that I was a midwifery manager did not appear to affect the intense nature of their responses.

4.3 Midwives' perceptions of the essential midwifery functions in the intrapartum period

The first theme discussed is midwives' perceptions of the essential functions of midwives in the intrapartum period. Three categories were grouped together in relation to this: ensuring the safety of the mother and baby, building a supportive relationship with the woman and providing support for birth partners.

4.3.1 Ensuring the safety of mother and baby

When asked to identify the most important function of midwives during the intrapartum period, the midwives indicated that it was ensuring the safety of mother and baby, a subject which they had not spent a great deal of time discussing in relation to other subjects that they appeared to find more interesting. The pursuit of normality was recognised, but they felt that not all women were going to have straightforward labours and that their job was to identify deviations from the 'normal' and act upon these appropriately, while also knowing when to sit back and not interfere.

> No matter how good and how clever we are there will be some women who are going to need assistance... It's knowing when to do something, knowing when it is abnormal, but also knowing when to do nothing and leave well alone. (Rachel, Group 7)

The midwives expressed the view that to help women through the process of childbirth, they have to know when women want to maintain control over the situation

and when they want to hand that control over to the midwife. It was asserted that as labour progresses, women do not want to be confronted with a multitude of choices. They want the midwife to assume control and make the right choices for them:

> I think a lot of women want to hand over that control and I think we are giving them all these choices and I think sometimes they don't want the choice, they want to be told what to do, 'cos it is almost like they have sort of lost control. (Amanda, Group 5)

The midwives recognised the vulnerability experienced by women during the childbirth process:

> They are very vulnerable at that stage, and they need to trust somebody who is going to give them a positive experience, who can keep them safe really. (Rita, Group 4)

It was mentioned that women often asked questions to try and assess how competent the midwife was likely to be:

> There is another thing about the safety thing I think some people like to know how long you've been qualified. (Pam, Group 2)
>
> Yes, and how many children you have got. (Grace, Group 2)
>
> Because I have been asked that, 'Have you been a midwife for a long time, have you got any children?', and I think they feel safe and reassured if you have, 'cos they feel that you have been there... But they are very wary about students, it's pertinent to them, you know, how safe is this all going to be with that person. (Pam, Group 2)

In order to successfully support women through labour, the midwives stated that it was essential that women believed in the midwives' ability to safely provide the care they need:

> I think confidence plays a big part in it, they need someone who is confident to instil self-assurance in them really... having somebody there who can help them through it and instil confidence in them, is a big part of our job. (Joyce, Group 1)

Generally, the midwives felt that not only did they need to be competent, but that they also had to display confidence in their abilities, in order for women to feel safe and secure during the childbirth process.

4.3.2 Building a supportive relationship with women

The second category concerns the issue of building supportive relationships with women that meet their individual needs. Generally, the midwives held the view that they were the most suitable professional group to build relationships and support women during labour, as opposed to obstetricians or obstetric nurses. As one midwife commented, others can provide care during labour, but midwives are generally a constant presence with the woman throughout the birth process. Knowing what type of care is appropriate for women was seen as one of the challenges of the role; one midwife likened this skill to being a detective, in that there is a need to find out how a woman copes with pain and what type of care best suits her personality. It was recognised that it is easier to build a relationship if the midwife has the opportunity to get to know the woman antenatally, but the ability to quickly establish a rapport and build a relationship was seen as a fundamental component of the role.

> It's trying to get to know somebody in a short space of time... and to get the women to feel that you are on the same level, that you're looking out for them and then they put their trust in you... (Hannah, Group 4)

The midwives acknowledged that sometimes they had to build up a relationship very quickly. This was regarded as being both unavoidable and difficult to achieve, but it was accepted as part of the role. Although midwives stated that relationship building was easier and more satisfying if continuity of care could be provided, it was agreed that it was the safety of the care given that was most important. It was felt that if the midwife was kind and caring, the woman could still be satisfied with her care, even if continuity of care could not be offered. The importance of being caring and supporting women in the decisions they make, especially when things do not go as planned, was stressed.

> If they have made decisions they need to be supported in their decisions, 'cos very often women come in with these huge birth plans of how they would like their birth and reality is not like that. You don't want to put them down or make them feel that they have failed, 'cos they haven't achieved what they wanted. (Kay, Group 6)

It was felt that ensuring women are supported is vital and that this can best be achieved by building trusting relationships, while gaining an understanding of womens' needs. The midwives felt that this was key to the woman finding labour a positive experience.

4.3.3 Providing support for birth partners

Under the category 'support for partners', the midwives articulated concerns as to whether husbands/partners were the best people to support women during labour. Although it was accepted that some men could be very supportive, the view was expressed that if men do not want to be present, it would be better if they stayed outside the labour room.

However, it was acknowledged that men are now under a great deal of pressure to be present during birth. It was felt that compelling men to be present when they really do not want to be, could have repercussions on marital relationships. It seems that the pressure to conform is very strong and it is sometimes seen as a sign of weakness or of being uncaring if men refuse to be with their partners when they are in labour. This view persists, even if they are unable to provide the necessary support. Indeed, from the evidence presented here, it seems they often require a great deal of support themselves to get through the labour.

> Some husbands or partners feel that they have to be there and really don't want to be there, but I think they are in a corner, that they are made to attend, whether they want to or not, or they are frightened of what other people will say if they admit that they aren't man enough to be there for the labour. (Chloe, Group 1)

The opinion was expressed that midwives should start asking whether partners want to be present during labour, rather than assuming that they do, and reassure them that it is all right if they do not want to be there. However, the complexity of the social

frameworks within which men find themselves coerced was not underestimated. The point was made that it can be difficult for men to accept labour as a normal, albeit painful, process, and as midwifery care often involves standing back and doing nothing unless issues occur, this can be interpreted by partners as the midwife doing nothing to ease the woman's suffering.

> They need a lot of support, and as we do in normal midwifery, we stand back and observe and they keep thinking, 'Do something for her, give her something,' it's just getting them to understand, this is normal... (Kay, Group 6)

A number of midwives were of the opinion that men can find the experience of being with their partner throughout labour and witnessing the birth traumatic, and it is easy for the midwife to forget about the partner and the effect birth events are having on him.

> I think it is quite important to try and involve the partner throughout the whole labour if you can, so that they feel part of it, 'cos a lot of them feel useless and they feel they shouldn't really be there, as it's a woman's thing. So involving them from the start with simple things like passing the water and that, it does help definitely. (Jenny, Group 6)

It appears that the partner's need for support increases the midwives' workload, for instead of having someone to help her support the woman, she finds herself in the position of having to support the partner as well. Most midwives accepted this and felt that it was now part of their role although it would appear that some midwives would prefer it if partners were not present at this time.

4.4 Relinquishing aspects of the role

The second theme concerns midwives' views about relinquishing certain aspects of their role. The three categories grouped under this theme are: jealousy and territorial attitudes, the consequences of staff shortages and the impact of MP roles.

4.4.1 Jealousy and territorial attitudes

Generally, the midwives acknowledged that they were territorial and protective of their role. They discussed their concerns about handing over aspects of their role to health care assistants or midwifery support workers (MSWs) (see Appendix 1 for glossary of terms). It was felt that delegating duties could result in midwives missing out on the more rewarding aspects of their work.

> I personally don't think it is the auxiliary's role to do things like help with breastfeeding and bathe the baby afterwards, 'cos you lose the continuity then and you are just doing paperwork and you are not doing, you know, that sort of nice thing with the mother that they appreciate.... (Alison, Group 1)

The issue of whether there is a place for MSWs was debated, but generally it was felt that only midwives should provide maternity care in straightforward cases. In addition to their concerns about the role of MSWs, the midwives appeared to feel generally threatened about the prospect of anyone else undertaking their role and voiced concerns about medical staff interfering in a normal childbirth.

The midwives expressed unease about the involvement of GPs in maternity care and questioned whether they were suitable health care professionals to provide this care, as they were not always up-to-date with current practice. Although there was apprehension about the involvement of GPs, the midwives accepted the need for senior obstetricians to be present in the labour ward to support the junior medical staff, but felt that their role there should be well defined and that they should not interfere in the care of women at low obstetric risk. However, the need to hand over care when issues arise was accepted without question; even so, medical intervention was regarded as being acceptable only if the case was complicated, as one midwife forcefully pointed out:

> To hand over a delivery to the doctors! Not unless it was indicated and needed. No, why should they be anywhere near the room? (Mary, Group 5)

Midwives jealously guard their role, which would appear to result from the fact that they find caring for women during labour and helping during birth to be both

rewarding and fulfilling. There was a sense that they felt this could be spoilt when others become involved in the process. In cases where medical staff had to attend and deliver the baby, the midwives felt that they had missed out.

> It's the climax as well, isn't it, yeah, you sort of build that woman up, you build this relationship up, you get her through and then you come to this pinnacle where she is actually going to give birth and then for them [obstetricians] to come and remove that, it is almost taking something away from her as well, 'cos they come in and destroy what you have built up. (Judith, Group 2)

Similarly, midwives also felt that, although they recognised the need to ensure student midwives acquired necessary experience, they sometimes resented having to hand their cases over to them. This issue was also discussed in relation to women employing the services of doulas.

> It might be difficult if they [doulas] overstep the mark. There is nothing worse than lots of voices in the labour room. (Leah, Group 3)

> Its sad you have to pay for a best friend. They are using them because they are not well informed, they could have had what the doula was offering from the midwife. It is sad that they couldn't approach us. (Wendy, Group 3)

The midwives did not appear to be aware that perhaps this level of personal care is not provided by every midwife in every maternity unit and that women might employ doulas and want their partners present because midwives are not always able to provide the support they need (see section 4.4.2). It was acknowledged, however, that the caring aspect of the role remains unchanged, even when others are involved in proving care and when responsibility for the management of the case has been handed over.

4.4.2 The consequences of staff shortages

In some of the busier units, the consequence of the pressure on midwifery staffing levels means that the use of MSWs is becoming essential for the safe provision of services. There was unease that staffing shortages meant that MSWs sometimes took over aspects of care, because the midwives did not have the time to do it all.

> I do think it takes away some of the enjoyment of the job though, cos I have worked in (name of unit) and in that time I never bathed a baby, I never put a baby to the breast, cos they'd always get there first, the health care assistants had more time to do that and that is not right. (Fiona, Group 6)

Anxiety was voiced that if aspects of their role were relinquished, it might result in midwives being expected to care for more than one woman in labour and the ideal of one-to-one care would possibly be lost. However, it was accepted that on occasion, the inadequate number of midwives available to provide care resulted in the need to delegate aspects of their work, and that this has now become an accepted way of providing care. When considering which aspects of their role they would be prepared to delegate in such circumstances, the view was expressed that work should be delegated only if the volume of activity in the unit warranted it. Some midwives felt that by delegating tasks to an MSW, they would be able to stay with the woman, and thus improve care. It is interesting that the midwife quoted below, while espousing woman-centred care, uses the language of sickness-centred care when she refers to the woman as "the patient"

> I think the auxiliary is there to support the midwife, not the patient, we are there for the patient, I think the auxiliary could be there to support us and that would be nice sometimes and you could say, 'could you rush and get this or can you pass me something', you know, we don't have that we have to go and get it and put down what we are doing to make a cup of tea. Whilst that is nice it's not always convenient. (Joyce, Group 1)

However, the opposing view was also voiced, that fulfilling the more mundane tasks involved in caring for a woman allows the midwife more of an opportunity to build up a relationship between them, and that the delegation of tasks might leave women dissatisfied with their care. The midwives felt that if too many aspects of care were delegated, it might pose a threat to the essential functions of their role.

4.4.3 The impact of MP roles

The development of MP roles extends the boundaries of midwifery practice, allowing them to manage complicated cases. However, this will unavoidably necessitate MPs making decisions regarding the plan of care, but trusting implementation to other

midwives. The midwives in the focus groups did not appear to have a great deal of understanding about the MP role and felt that MPs did not have a large impact on their own work. Some midwives felt that the development of MP roles was a natural progression for midwives, but others seemed unsure about their effect and queried how far these posts would move practice away from normal midwifery.

> But is that midwifery? Are we breaching what midwifery is, you know to be with woman? I can see where it can be, but I don't know... A lift out ventouse is not a big thing, but it is still outside the remit for some midwives. (Emily, Group 7)

There was diversity of opinion among midwives about MP roles. The view was expressed that MP posts have unjustified prestige and participants felt that they were perceived as being superior to other jobs in midwifery. While some midwives argued that MPs regarded themselves as being superior, it was also claimed that MPs were being exploited for the benefit of the medical profession. Conversely, the view was expressed that midwives should make use of the opportunities these posts provide, to develop the midwifery profession and improve care for women. Others felt that these posts could help promote normality and reduce interventions and that the midwifery experience of MPs would make them more efficient and better able to communicate with women than junior doctors.

> The MPs have got the same skills as us, there's no reason why they can't use them for those women, because she's still going to be with the woman.... building that relationship with the woman, why can't that happen? She can still do that and be on a par with her medical colleagues. (Judith, Group 2)

A number of midwives felt it was necessary to accept the diversities of the midwives' role and accept that each type of role has its benefits, as specialisation was unavoidable:

> I think midwifery is becoming so skilled now that you are going to have to go off to an area you can specialise in, you can't be good at everything. (Fiona, Group 6)

There appeared to be a degree of ambiguity about the MP role, while midwives were concerned that such posts would not be midwifery posts, others felt that such developments were inevitable and offered opportunities to improve care provision.

4.5 Midwives' views of how they are perceived by others

The third theme explores midwives' views of how they are perceived by other health care professionals and clients. The three categories that emerged concerning this were: midwives being seen as difficult and elitist, being 'invisible' and misrepresented and having to demonstrate their worth.

4.5.1 Difficult and elitist

The midwives expressed the view that other health care professionals had a poor opinion of them and that they were often described as being difficult and elitist. The view was also articulated that if midwives wanted help or assistance, it was often wise not to identify themselves as midwives:

> Madwives! Yes, madwives! I mean, what is that about? I'd rather not say what I do, if I want them to be nice to me. (Joyce, Group 1)

It was stated that doctors often felt that midwives were more difficult to work with than nurses and they are apparently warned about the reputation of midwives while they are still medical students,

> Well the medical students are always warned, "never cross a midwife", I've heard that said. (Gloria, Group 4)

It seems that midwives can cause a great deal of concern to junior doctors during their obstetric placement, and that midwives seemed to enjoy the power this gives them. However, it was argued that midwives become assertive so that they can be advocates for women.

It was also felt that challenging the decisions of medical staff does not always have to result in conflict, and if managed diplomatically, it would not necessarily result in obstetricians having a negative view of midwives. (Note the use of the term "patient again, by a different midwife.)

> If the SHO orders something regarding patient care and you don't think it is appropriate, you'll ask, why they suggested it, and then we come across as being 'bolshie' and obstructive, but we are not, I mean there are ways of doing anything, and I think you can do it and get away with it, without getting a name for yourself or you can be stroppy. (Dawn, Group 4)

The midwifery profession is linked closely to nursing and in NHS hierarchies, midwives report to nurses at the Trust board level. However, the general opinion was that nurses see midwives as being elitist and detached from them, and that they do not always look upon them favourably. It was mentioned that when nurses decide to undertake further training to become midwives, they are often warned about the reputation midwives have. A number of midwives also felt that nurses resented the fact that midwives had a different title, rather than just being regarded as nurses who specialised in a specific area. There were a number of comments made that the midwifery profession was far more advanced and had more autonomy than nursing. Notwithstanding this, many midwives expressed the view that they were not able to practice autonomously and that nurses were increasing their own level of autonomy.

The midwives expressed the view that their reputation was unwarranted, however, they also appeared somewhat pleased with the way they were perceived. They felt that this enabled them to be advocates for women and that it resulted from their level of autonomy.

4.5.2 'Invisible' and misrepresented

It was recognised that often the general public does not understand what the midwives' role involves and that in the media, they were either 'invisible' or misrepresented. The main opinion was that the general public still tended to think of midwives as nurses, and it was felt that as a result of this, midwives were perceived as being assistants to doctors and not regarded as autonomous practitioners. The view was expressed that often midwives feel there is a perception that they work as obstetric nurses, as a result of this, women were often surprised that the doctor would not attend the birth:

> I think there still is a misconception, that midwives are nurses and obviously nurses assist doctors. Therefore, midwives are certainly not best placed to be delivering babies, because, surely that is the doctor's job. (Chloe, Group 2)

Initially, some midwives felt that they did not need to explain their role, assuming that it was generally understood, but after considering this issue, the general view was that this is probably incorrect.

> And they ask what you do and I say I am a midwife, but nothing else is required they say, 'oh how lovely, I've always wanted to be one of them'... I often don't need to or I perceive I don't need to. (pauses) This is complicated 'cos I think they know what I do but in reality when you read other stuff you think perhaps they don't know what I do. (Emily, Group 7)

It was also felt that the private and personal nature of the midwife role sometimes prevented them from discussing their work. It was mentioned that the media tends to portray midwives in a negative fashion and gives a false image of the midwife. The 'soaps' in particular sustained a lot of criticism from midwives for the way they are portrayed therein:

> Very rarely do you hear the word midwife, you always hear doctor and you always hear "nurse', it is very rare in soaps generally that we ever hear midwife. (Gloria Group 4)

The view was held that generally, the only time midwives were mentioned in the media was when a midwife had done something wrong, and that their achievements were never reported. However, the view was articulated that after women had babies, their previous images of midwives were replaced by a better understanding of the role of the midwife. It was felt that the confusion about the role might have resulted from the fact that the role has changed so much during the last century, as a result of changing healthcare policy.

4.5.3 Demonstrating worth

The midwives were generally enthusiastic and felt that their image was improving, though it was acknowledged that they still had a long way to go before they gained

the same status as obstetricians. The midwives contended that healthcare policy resulting in the medicalisation of childbirth had a negative impact on the way midwives were perceived, as it resulted in midwives becoming hospital-based and obstetricians being given overall responsibility for the management of care provision. In reality, unless major changes take place in both professions, midwives will never gain the same status as obstetricians. It was good to hear that midwives aspired to this increased regard.

> We have been downtrodden by the medical profession over the years. You know after the time when birth was placed in the hospital and became medically dominated and it moved from the social aspect into the medical model and that was lost, but now I feel that is being regained. (Chloe, Group 1)

There were many comments that the establishment of Birth Centres have made midwives more visible in the community and improved their image. However, even though healthcare policy supports such developments, there were experiences in the groups related to public protests when consultant-led units became midwife-led birth centres. This resulted in midwives feeling that they were still viewed as being not as competent as obstetricians.

> Having been involved with the situation [i.e., the establishment of a birth centre] and the public consultations there, it's an awful thing to say, but I think the public viewed us very much as second to obstetricians and that is very sad... (Judith, Group 2)

Nonetheless, it was felt that the views of obstetricians towards midwives were improving – though it was noted that midwives still held the view that they had to gain the approval of medical staff:

> I think a lot of the groundwork that goes on in some units is to build the confidence of our medical colleagues, to say that we as midwives are safe practitioners; we have to defend what we can do. (Emily, Group 7)

There was conflict over the need to avoid undermining obstetricians, to ensure women retained trust in their abilities, even though obstetricians do not seem concerned about undermining midwives.

> ...Oh yeah, but you have to be very careful how you do it so you don't undermine the doctor, because at some time later the doctor may be called and you don't want to undermine the doctor... (Sian, Group 5)

> The thing is they don't worry about undermining us in any sphere of midwifery practice... and I don't see why we have to prove our worth to doctors, why do we have to prove to them that we are able to be midwives, any more than they have to prove that they are able to be a doctor to us? (Nicola, Group 5)

In addition to proving their worth to obstetricians, it was the opinion of many of the community and birth centre midwives that they had to demonstrate their worth to their hospital colleagues. It seems that the view is sometimes held that community midwives have less expertise than hospital-based midwives, although this was hotly disputed.

> The midwives working in the District General Hospitals don't understand what our role is and I think sometimes when you transfer women you are almost made to feel like – hand it over to the real professionals, we will deal with this, you lot have got straw in your hair... These women are safer here now. (Chloe, Group 1)

However, it was felt that obstetricians were beginning to acknowledge the expertise of midwives. Many of the community-based midwives felt that this had been achieved by community midwives working more closely with GPs and being more confident and accustomed to working on their own initiative.

It appears that with the development of midwifery led care and team midwifery the relationship between midwives working in different settings has become strained and divisive. Although midwives describe themselves as being autonomous practitioners they still felt that they needed the approval of obstetricians. Even when the role changes to give midwives more autonomy this is not seen by the public and is not recognised and supported by other midwives.

4.6 The experience of midwives working in the NHS

This theme explores the views and experiences of midwives working in the NHS in the UK and the factors influencing the role of midwives. Three categories were

identified: pressure to conform, issues with midwifery training and cyclical changes within the NHS.

4.6.1 Pressure to conform

An issue that caused particular unease was the perceived pressure from obstetricians, midwifery managers and, interestingly, from midwives themselves, to avoid changes to the system. The view was expressed that some senior midwives may resent and feel threatened by more junior midwives who are keen to take on more autonomous practice and responsibility. There appears to be a great deal of pressure to make midwives 'fit in' to the system. Some birth centre midwives discussed this issue and the fact that this pressure is not felt by midwives working in birth centres, where they feel they are able to be more autonomous.

> You would fit in after a while because you would get de-skilled... (Anwen, Group 1)

> You would either have to do that or you would leave and that is probably why so many midwives have left the profession in the last ten years, because either you knuckle down and get on with it or you do something else. We are lucky because we have this [birth centre], whereas they perhaps haven't [got one] and end up getting out of the job. (Joyce, Group 1)

The midwives who worked in the birth centres stated that they did not feel this pressure, as they are more autonomous in their practice than their counterparts. However, many midwives also mentioned the excitement and drama of working in a hospital setting:

> Well I think a surprising number of midwives are prepared to be obstetric model type midwives, because [name of hospital] are currently becoming midwifery led and there is a big divide among the staff, some think it is really positive and wonderful and others are absolutely dreading it and they really don't want to take on the holistic model of midwifery. (Alison, Group 1)

Midwifery managers also sustained a great deal of criticism from midwives who felt that they did not understand the issues and difficulties of clinical practice. Midwives

voiced their concerns that managers do not listen to what clinical midwives feel are important issues:

> Managers do not take on board what front-line staff say, they insist on rigid practices. (Geraldine, Group 3)

The opinion was also articulated that managers have unrealistic expectations of midwives:

> A lot of it [pressure] stems from the top.... You may have only one or two calls but that one call may take you two hours because there is a problem and they are looking and thinking, "What is she doing all day?" (Nicola, Group 5)

The hierarchical systems of the NHS were perceived as being responsible for placing additional pressure on midwives to conform. Generally, the midwives felt they were answerable to too many people. This was felt to be the case even at the ward level, where interference by ward and unit managers was regarded as having a negative effect on care. The midwives also asserted that if they are to promote normality, there is a need to move away from the pressures of the hospital setting. A number of midwives commented that there was a 'blame culture' in operation in many hospital maternity units, which increased the pressure on midwives to conform. It was also felt that midwives did not support each other:

> I have only been out on the community two years and prior to that, for the vast majority of my career, I've been a labour ward midwife, I now go back and work on the labour ward for our agreed days per month and I can honestly say the way some midwives look at you and speak to you infuriates me, it is insulting. (Mary, Group 5)

This often results in midwives feeling stressed and demoralised, which can have an impact on retention and so reduce staffing levels, which tends to cause even more pressure. However, this lack of support from colleagues was reported only in the hospital setting, the view was expressed that community and birth centre midwives were far more supportive of each other. These midwives were much more positive and felt that their work brought them a great deal of satisfaction.

> We've got a lot of job satisfaction here so if this model went further out then a lot more midwives perhaps would stay within the profession and not leave,

> because as well as the women getting the total package, the midwife would also get job satisfaction and would stay in the profession rather than leave. (Grace, Group 2)

4.6.2 Issues with midwifery training

Generally, the midwives in the current study said that the present midwifery education system teaches midwives to be autonomous practitioners, but that they are then expected to work as obstetric nurses, which leads to a great deal of frustration and stress:

> ...I think [midwives] are taught in university to be autonomous, but they go to work in hospitals where they can't practice in that way and then it gets whittled away and it just wears them down. (Joyce, Group 1)

However, midwives were generally of the opinion that student midwives are becoming more assertive. Nevertheless, there were concerns regarding whether they would be able to change the system or whether the system would change them. There also appeared to be a lack of harmony between universities and maternity units about the perceived needs of students. There was concern over whether current midwifery training concentrates too much on theoretical learning, with not enough emphasis placed on developing clinical skills.

> It is difficult to get the balance right; we want a profession and we want to be regarded as professionals along with other professionals who are degree-based, but at the same time it is a practical job and, I mean, when I did my training we had degree nurses coming and they were very difficult to work with because they couldn't organise and manage... (Hannah, Group 4)

There was a great deal of concern about the lack of clinical skills possessed by newly qualified midwives and the support required as a result of this:

> Well, it is stressful, isn't it, when you are newly qualified? I find newly qualified midwives now seem to need more support when they first qualify than they used to; they really lack confidence in basic, fundamental clinical skills. (Rachel, Group 7)

Nevertheless, the midwives held the viewpoint that there is a need for both academic study at degree level and sufficient practical experience. The length of training was also questioned. Some midwives mentioned that the 18 months of post-nurse registration training was too short a period to obtain both a degree and the requisite clinical skills. It was the opinion of many midwives that the three-year, direct-entry training may prove to be the solution to this issue:

> I think, though, the three-year course [direct-entry midwifery training], so they don't do any nursing, would be better. I used to be opposed to that, but I think in a way you have a mindset, where they haven't got that nursing model, you know, they go in as a midwife as opposed to being a nurse first... (Alison, Group 1)

The midwives generally held the view that direct-entry midwifery training may have an additional advantage, in that it would stop nurses from training as midwives just to enhance their career prospects, and that it would also remove the option of midwives returning to nursing if they find midwifery practice to be too problematic.

4.6.3 Cyclical changes within the NHS

The issue of the medicalisation of childbirth was discussed in detail. All of the groups felt that the medicalisation of childbirth in reducing the status and autonomy of midwives continues to be an issue that impedes midwifery practice:

> Things have gone around in a circle; maternity care became medicalised and we are now seeing more normalised maternity care, but the position of midwives is still not as strong as it should be... (Mirium, Group 3)

The opinion was voiced that pressure from consumer groups has been beneficial to the development of the midwifery profession and that demands to normalise childbirth resulted in midwives becoming accepted as the lead carers for women at low obstetric risk. However, it was also acknowledged that consumer pressure has resulted in unrealistic expectations about maternity care:

> I have two caseloads and one is from an affluent area and they have read everything and expect everything. (Carla, Group 5)

The history of maternity services was described by midwives in most of the groups, in terms of a circle or a pendulum that has swung from midwives being the main providers of maternity care, to a point where medical staff claimed control over maternity care provision. It was felt that gradually the pendulum was swinging back to the point where midwives have started to reclaim their role:

> Midwives shouldn't let that happen again for future midwives, or for the women, we shouldn't allow that to happen.... Perhaps we will all fight harder this time for it to never happen again. (Pam, Group 2)

The midwives expressed disquiet that healthcare policy recommendations to develop maternity services further had resulted in additional pressure on midwives and that, in some cases, this had reduced the standard of services provided. Some midwives regarded a lot of recent developments as being ineffective, in that the achievements resulting from alterations are wiped away by the next change, leading to a lack of commitment from midwives and confusion for women:

> We have had a lot of change thrust upon us in the last five years and at the moment we are not doing any of it particularly well, because we are concentrating on making all these changes and before we have actually had time to really deliver that change well, we have got another one.... I think we have gone change crazy, to the detriment of women. (Bev, Group 4)

Generally, the midwives in the current study maintained that the cycle of change was moving from a position where medical staff had control over maternity services to a point where midwives were starting to reclaim more control over the provision of maternity care:

> I actually think that we are reclaiming midwifery care and this is what it is all about, and I think that it is very positive. (Rita, Group 4)

It would seem from the findings of this Phase of the study that midwives have a clear understanding of their role and which aspects they would not want to lose. However, it seems that, currently, midwives – with the exception of those working in birth centres – are unhappy with the constraints and changing demands of their working lives. Midwives appear to be dissatisfied that they are not able to practise in the NHS in an unconstrained way that fits with their philosophy of midwifery care. The

existence of MPs cannot alleviate this dissatisfaction, but by encouraging midwives to extend their role and work in a more autonomous fashion the job satisfaction of MPs at least, might improve. The findings of this initial part of the study provide a baseline understanding of the current role of the midwife in Wales. It also provides insights into how midwives perceive the MP role, which will allow the next stages of the study to be explored in context.

CHAPTER FIVE – PHASE TWO RESULTS

One cannot know, either simply through detachment and objectification; one must gain knowledge through participation. Language and communication are vitally important, because our concepts depend on the language available to us. Persuasion – the recognition of the other person's point of view and the accommodation of one's arguments to that point of view – is essential for comprehension and the development of ideas. (Haste, 1993:33)

5.1 Introduction

Phase two of this study employed participant observation to see and hear how MPs practise and how the way in which they work impacts on midwives and obstetricians in the research setting. The findings from Phase one were used to place this Phase of the study in context. The results of Phase one of this study provided baseline information about the role of the midwife in Wales at this specific time. The results showed that the midwives had a clear understanding of their role, in that they provided safe and supportive care for women and their partners during normal childbirth. They seemed to accept without question the need to refer women who develop complications to obstetricians, though there was some resentment about obstetricians taking over and 'spoiling things.' However, the midwives were very protective of their role and resented handing over other aspects of care, though there was an acceptance that the involvement of HCAs in maternity care was unavoidable. The reputation of midwives was perceived as being misleading and negative, and they were seen as being somewhat insular within NHS services. Generally, they perceived themselves to be under a great deal of pressure to conform and to work within an ever-changing work environment. This resulted in resentment and dissatisfaction with their practice.

The midwives had not generally considered the role of MP and its possible impact upon other midwives and they expressed a degree of ambiguity about this new role. However, the general view was that MP posts would not have a great deal of impact upon their practice. The findings from Phase one allowed me to have a clearer understanding of how midwives and maternity units operated, along with the organisational and professional relationship issues that existed in this particular

workplace. This understanding was of great benefit in embarking upon participant observation and allowed me to focus upon specific issues, such as how midwives might react to making referrals to MPs and whether MPs practiced in ways which improved care, for example by encouraging improved communications with women.

This chapter outlines the results of Phase two of the study. Ten categories emerged from the data gathered in this Phase of the study and were grouped under four themes (see Appendix 11 for the table outlining the stages of coding). The four themes identified were: interaction with women, affiliation with other midwives, integration with obstetricians and developing practice. The findings are presented in the form of narrative description and quotations from the MPs who participated in this study. The chapter begins by providing details of the research setting for Phases two and three of the study.

5.2 Research setting for Phases two and three

5.2.1 Details of Trust maternity services

Maternity services are provided on two sites, a five-bed Birth Centre situated in one of the Trust's small hospitals and a thirty-one bed consultant/midwife-led unit situated on the District General Hospital site, (this is where this study was undertaken). Integrated midwifery services are delivered by two teams of midwives providing care for women booked for consultant led care, and by two teams of midwives providing care for women booked for midwifery led care. In addition, a 'core team' of midwives is permanently based at the maternity unit on the DGH site. Medical services are provided by four obstetric/gynaecology consultants, seven middle grades, six junior doctors and three midwife practitioners.

5.2.2 Layout of the maternity unit

The nurses' station is situated to the right of the entrance door of the labour ward, it houses phones, a computer, case-notes and necessary stationery. The midwives and doctors tend to congregate here. Opposite the nurses' station are two delivery rooms, one to the left and one to the right, separated by a short corridor which opens out into

an area that has a delivery room and an office to the left and a delivery room and a kitchen to the right. There are two tinted bay windows, with glass from ceiling to floor in this area giving a view over the car park and down the valley. There are seats in front of each window and midwives use the ones outside the kitchen during their breaks. There is also a computer and a blood gas machine in this area. To the left of the nurses station is the sluice and to the right a storeroom. The corridor to the right of the nurses' station has doors on the left hand side leading to a delivery room and two recovery rooms. At the end of this corridor on the right are double doors leading to the obstetric theatre.

On first appearances, the entrance to the labour ward seems cluttered, the nurses' station and nearby walls covered with lists of various phone numbers and information notices for staff. In spite of some posters and pictures on the walls it gives the impression that it is a place for staff rather than for clients. The walls are painted a pale yellow with a green flowery border along the top, the doors are painted a subdued green, and generally the décor is relaxing and quite well maintained. In the labour rooms the walls are painted in pastel colours and there is a curtain around each door to give privacy, but this arrangement makes the rooms feel small. The essential equipment in the room, such as monitors, resuscitation equipment and delivery trolley, make it look clinical instead of being a relaxing place to give birth. During the night the Labour Ward is quiet and noise from the heating audible.

Ward 21 is the combined ante/postnatal ward, it has three six-bedded bays, two cubicles and a three-bedded early labour room. When not providing care for clients midwives spend most of their time at the nurses station and in the ward sitting room.

5.2.3 Medical and midwifery staffing

During the time of data collection for Phase two the junior doctors were still on-call when the MPs were on duty in case they needed assistance. This continued until February 2005, which gave the MPs sufficient time to consolidate their skills before working without this support. During the time I worked with the MPs they did not contact the junior doctors for advice or assistance. There is always one middle grade

obstetrician present in the unit, but they tend to stay in the on-call rooms until called. There are normally five midwives and one MSW on duty at night.

5.2.4 Researcher's impressions during the period of participant observation

During the period of observation I wore a scrub suit, which is what the MPs, medical staff and some midwives wear. I seemed to be accepted by both staff and women and found it surprisingly easy to 'fit-in.' Initially there seemed to be an expectation that I was there to assist or monitor staff, but this quickly lessened as staff became more aware of why I was working in the unit during the night shift. I have attempted to clearly identify which events led to the development of the themes and wrote comments at the end of each shift to further clarify this and describe my thoughts and interpretations. I found that I experienced some dilemmas during the participant observation. The view of the middle grade obstetricians, that they were on-call and should be allowed to sleep, was difficult to accept when I was aware that they were being paid to work a night shift. I also found it hard to keep quiet when the MPs were prompting the midwives to identify problems. They were not wrong in doing so but it demonstrated my impatience, and our different styles of dealing with such situations. During this Phase of the study I became more aware of the medicalised language used by the staff (including myself). Women were referred to as patients or by their conditions for example 'the section of yesterday.' This use of language was also noted in the interview transcripts from Phase one of the study.

5.3 Interaction with women

The first of the themes discussed is interaction with women. Two major sub-categories were grouped together to form this theme, these are developing a rapport with women and their birth partners, and meeting women's social and emotional needs.

5.3.1 Developing a rapport with women and their birth partners

The MPs were able to build a rapport very quickly with women and their families. It was noticeable that the MPs were able to move rapidly from one client to another at busy times, they seemed to enjoy the variety and did not let this affect the way they communicated with women. The MPs were able to speak to women in a way they could relate to and understand, and they were also effective in dealing with difficult clients. When Ann, for example, was called to see a woman who had been involved in a fight, she managed the situation well, convincing the woman to agree to an assessment and treatment in spite of the fact that both she and her partner appeared to be heavily under the influence of alcohol. It was noticeable that the MPs actively encouraged women and their partners to talk, making an assessment more of a conversation than a consultation. It seemed that they were using the skills that they had formerly developed as midwives to do this.

> I think we [midwives] are taught to communicate a lot differently to the doctors; it is coming down to the clients' level and trying to explain things more so they can understand and encourage questions and ask them 'are there any questions you would like to ask me, is there anything you would like to know' and the same with their partners, 'cos you find their partners chip in a lot then, once you explain things they will join in the conversation. (Ann)

The MPs identified the need to reassure women and their partners, helping to allay their fears and calm them down during difficult situations. In spite of the rapport they were able to establish with clients, the MPs were still surprised at the unquestioning acceptance they received from women. They originally thought women would feel that only a doctor could undertake this type of work.

> Well I think they are all very accepting, there hasn't been anyone who has said anything derogative or that they wanted to see a doctor, even in gynae. I always say to patients, 'If there is any reason I think you need to be seen by a doctor you will be reviewed tonight, otherwise you will be seen by a registrar in the morning', and they all accept that. (Sara)

The MPs seem able to develop a rapport quickly with both women and their partners by speaking to them in a way that they can understand and by encouraging them to participate in discussions. This sub-category confirms the views expressed in Phase

one (section 4.4.3) that MPs would be better able to communicate with women than would doctors. Women and their families appeared to accept being seen by a MP rather than a doctor without question.

5.3.2 Meeting women's social and emotional needs

One of the advantages of the role is that MPs are able to consider women's emotional and social needs, as well as their physical needs:

> They [women] have been fine, nobody has had a problem with me; I think if you are approachable, kind and treat them as a whole... holistically, then they are fine with you, I think they like that. (Lyn)

This is something that doctors do not always consider, as they often see their role as relating solely to the clinical management of medical conditions, the reductionist nature of the medical model. The MPs also discuss health issues and provide advice during their conversations with women. They may also provide the link between midwifery and obstetrics, which may further improve and develop multi-disciplinary working. While the MPs are learning from obstetricians, it seems that obstetricians are also learning from them.

> One of the junior doctors said something interesting the other day; she said, 'You as a midwife would probably do a postnatal discharge completely different to me, you will go into contraception in a lot more detail than me, I will just stand at the bottom of the bed and say what are you going to use,' and I said, 'You want to sit closer, you really have to get in there and explain how their body works,' and she said, 'that is the difference between us'. (Ann)

It seems that doctors do not always have the confidence to use their expertise to help in areas of women's lives that are not directly linked to the diagnosis. The MPs speak to women in the same way as midwives speak to them. It is a general conversation between people on the same level, rather than a clinician making a diagnosis and ordering the management of care. It was clear that the MPs made an effort to deal with the whole situation, and not just the clinical issue. During a conversation Sara had with a woman – who had been admitted with hyperemesis – and her partner, she talked to them about hyperemesis, the woman's previous pregnancies and home

births. The woman's other babies were born in England and she had problems arranging a home birth there, but Sara reassured her about this. After her partner left, she confided to us that she was worried, because she could not work or look after the family, and she needed to keep working to support her partner through college. Sara empathised with her predicament and reassured her that the condition would pass as the pregnancy progressed. During another consultation, Ann made the decision to advise a woman to stay in hospital, she explained the reasons for this to the woman and her partner and discussed their worries about childcare. Her partner agreed that he could cope with the children and Ann eventually convinced the woman to stay in hospital.

All of the MPs felt that their continued presence on the labour ward would enable them to become involved with cases at an early stage, and not just when problems arise. This would result in women having the opportunity to get to know them and would provide the chance for them to offer support to the midwives.

> I think for women it's got to be better, because during labour, if there are any problems by night, you would be involved from an early stage and you would be there supporting the other midwife, so you build up a relationship with the woman and her partner, so if there are any problems they already have trust in you, it's another face they know. (Sara)

The MPs are able to use their midwifery skills to provide holistic care, which takes into consideration women's emotional, social and physical needs while providing appropriate health education. It was noted that they are starting to help medical staff develop these skills.

5.4 Affiliation with other midwives

Three sub-categories were developed: striving to belong to the midwifery team, midwives' expectations of MPs and ensuring midwives retain control over care. These sub-categories were grouped together under the second theme, which is affiliation with other midwives.

5.4.1 Striving to belong to the midwifery team

The MPs appeared very keen to become accepted as members of the midwifery team and employed various tactics to achieve this. They regularly praised the midwives and thanked them for their support:

> I think if you praise the good things, then you are accepted, because I don't think we do enough of that – we don't say "well done", we always clamp down on the bad things. (Sara)

It was also noticeable that the MPs were keen to help the midwives with assignments for courses in which they were enrolled. This seemed to be to help develop the midwives' knowledge and expertise, but also to help the MPs 'fit in' and become accepted by staff.

The MPs were aware of the need to appear confident when dealing with experienced midwives and were surprised that these midwives valued their opinion. When the unit was quiet, the MPs sat and chatted with the midwives and seemed to get on well with them. During the observation period, the MPs did appear to be accepted as part of the midwifery team, in spite of the fact or perhaps because they had not previously worked in the unit as clinical midwives. This may also have been because they were able to offer more assistance than the doctors.

> The MP role has been widely accepted here and they [midwifery staff] do see you as part of them, 'cos if they are making a cup of tea or anything they will also ask me, whereas they don't ask the doctors and I think it is partly because you do everything... I don't need chaperoning, I will go and get my own equipment, it's the same in theatre, I can do everything, from transferring the patient from the trolley to the bed, to helping with the swab counts. (Sara)

However, the view was expressed that the MPs do not really feel part of any one team and were still trying to work out where they fit into the staffing structure:

> I think you feel part of all the teams really, midwives, doctors, managers and your own team (MPs). But you are not really a member of any of the three and maybe that's the difficulty. (Lyn)

This was also felt to be problematic by another MP, who had previously had a strong identity as part of a midwifery team. However, it has to be acknowledged that these posts are still relatively new and perhaps, with time, they will either fit into one group or establish their own identity as MPs.

> It is very difficult to define at the moment, it's like you're in 'no-man's land': you're not a doctor, you're never going to be a doctor, then the midwives don't really see you as being one of them, so it's a little bit of a grey area. You're trying to develop your own role, your own skills, but at the same time I can't really tell you, I don't know where I am, I don't know *[laughing]*. (Ann)

In spite of the fact that the MPs felt they were on the periphery of a number of different teams they still felt that they wanted to integrate into the midwifery team and made a conscious effort to do so. It is an essential component of the MP role to work across speciality boundaries. However, all of the MPs felt somewhat vulnerable in that they did not fully belong in any professional group. This may be a weakness, but may also lead to a cohesive relationship between the MPs themselves. It may also result in the boundaries between midwives and obstetricians merging, encouraging greater harmony between two groups, who have traditionally been in competition with each other over the provision of maternity services. It may emerge that MPs combine the best traits of both professions and comprise a whole new "animal".

5.4.2 Midwives' expectations of MPs

The MPs' relationship with the midwives appeared to be very good. The MPs seemed friendly and approachable and were prepared to assist the midwives. However, it was noticeable that the midwives do not give MPs the same level of assistance they would offer doctors. MPs generally examine clients without any assistance and were also expected to put women into bed and settle them. There did not seem to be a deliberate intention to expect the MPs to undertake additional duties, but it was assumed that they were part of their team and should provide assistance. However, this would not be expected from junior doctors. On occasion, this assumption caused some dissent. When the labour ward became busy, my impression was that the midwives felt the MPs should be helping out – but they must also be available to respond to calls from other areas, so have to limit the help they can offer.

> I haven't had a night yet where they have all had a patient, but they do look at you and think, 'well, are you going to take one?', but then it's not what the job is about and you can't really afford to do that, so I will say, 'I can't take a patient for you, but I will help out,' and it has been really appreciated. (Ann)

The MPs acknowledged the difficulties in dealing with the issue of assisting the midwives and felt that it was important to establish ground rules:

> I think it was easier to do in a Trust that I haven't worked in before, as I was able to set the boundaries from the beginning; I think it would have been far more difficult in a place where I already worked. (Sara)

It was felt that there was a need for midwives to accept that the MPs could not provide all of the assistance the midwives would like, as Lyn explained:

> At the beginning I found it difficult to stand back and not get involved, but you realise you have got your own work to do as well, but if it is busy and I can help, then that is fine.

When midwives identify an issue and call the MPs, they often appear to know what needs to be done, but are happy for others to make the decisions for them. This may be related to the issue of conformity discussed in the Phase one (see section 4.6.1). Perhaps they do not want to change, as it might then be expected of all midwives, even those who do not want to change. The MPs recalled being like this in their previous jobs. On one occasion, when a midwife undertook a procedure that she was capable to perform, she obviously felt uncomfortable about having done it and justified it by saying she had done it because the MP had been busy. This attitude was noticeable, even among experienced midwives.

> I was called to the labour ward to review a CTG [cardiotocograph]. The person who called me was a very senior midwife who I respect enormously. We both interpreted the CTG together and agreed that it was a normal reactive trace. I wondered why she felt the need to ask for a review, it's not that I minded, but I feel that most of what I am doing at present, the midwives that I work with are more than capable of doing, but they know that it is sometimes easier to pass responsibility on. (Ann)

It was observed that the midwives sometimes seemed unconcerned about a woman, after they had called an MP or doctor for assistance. It seemed that they were happy to

pass on the responsibility for decision-making and then feel that they could criticise those they referred to, for being conscientious. (Although they did not articulate their concerns, this was apparent from their body language). If midwives are to be taken seriously as professionals, they must take responsibility for their decisions in the same way that MPs and doctors take decisions regarding plans of care and interventions and do not hand over responsibility to anyone. This was observed to be one of the main differences between MPs and midwives and is something that, if acted upon, might improve the image and status of midwives. The findings from this Phase of the study do not support the midwives views in Phase one (see section 4.5.1) that they are autonomous and are prepared to be unpopular to be advocates for women.

The MPs seemed to have developed the type of confidence and authority when making decisions that medical staff members normally demonstrate. They did not seem to worry about this responsibility in the way in which the midwives did and seemed to be more analytical when making clinical decisions. When discussing how her decision-making had changed, Sara felt that this change had been more noticeable to her when dealing with gynaecology patients:

> It has [been more noticeable] in gynae 'cos I would have called an SHO if we had any gynae problems; now I have to make that decision.

Meanwhile, Ann felt that the change was noticeable in all areas of her practice:

> I can see a big difference in myself, 'cos it is probably not long ago that I was one of those midwives who would think, 'Well, I've done my bit, now let's hand her over to the next person', so as far as you can see you have admitted them, assessed the mother, assessed the baby and then documented it and that's it, everything is dusted, signed and handed over to the next person for them to manage it, now the management stops with you, you have to think about it more... and all of a sudden it's funny, it's like the fog is clearing. (Ann)

While the necessity to make decisions and take action was acknowledged, the need to intervene only when necessary and maintain normality was also a consideration:

> It is just looking and thinking "Well, we have done her vital signs, we have done the monitoring and there is no fetal distress, everything is fine, there is no reason to be worried." (Ann)

The midwives' expectations that the MPs are able to help with midwifery duties during busy periods were not realistic, as the MP role has different responsibilities and areas of practice. However, when it came to making decisions about complicated cases the midwives seemed happy to defer to the MPs and to avoid taking responsibility for decision-making.

5.4.3 Ensuring midwives retain control over care

The MPs are very cognisant of not taking over from the midwives in terms of overall care. The MPs also promote decisions as if they were the midwives' idea. During week one, Ann stated to a midwife, 'That baby's breathing sounds a bit off'; the midwife considered this and then came to the conclusion that the baby needed to be seen by a paediatrician. They also encourage midwives to say what they think should be done. A conversation took place during a phone call with a staff midwife regarding whether she should give a woman Pethidine when she was not in established labour, but who was very distressed. Sara asked, 'What do you think we should give?', to which the midwife replied, 'I think she could do with 50 mg of Pethidine.' Sara stated, 'Yeah, I think that would be a good idea; give her that and see if she settles.' This was a simple decision and the midwife just needed a bit of encouragement that she was doing the right thing. The ability to promote ideas as if the other person has thought of them is a skill that midwives often use when dealing with doctors.

MPs are diplomatic when asking midwives to carry out their instructions and act in a way that ensures the midwives maintain dignity and do not feel uncomfortable or foolish about asking for advice. As Ann summarised:

> It is important, the way you ask midwives to do things; sometimes you have to go in a roundabout way to get them to do what you want them to do, as it is important to keep them on side so they work with you, if they realise that you have made a good decision once they will accept your decisions in the future.

The MPs tried whenever possible to let the midwives manage their own cases; as Sara explained:

> The midwives don't like it if you take over, so you do what's needed then take a back seat, as it is their case, not yours.

During busy situations the MPs undertook work to assist the midwife, rather than taking over the perhaps more glamorous aspects of care, as the following scenario shows. The labour progressed from a uterine cervical dilatation of four centimeters to full dilatation in half an hour. The fetal heart rate decelerated and stayed down. The middle grade was called and did a ventouse delivery, the junior paediatrician was present and the room became crowded and busy, Sara positioned herself out of the way. The baby was born in a poor condition, the paediatrician and the obstetric middle grade resuscitated the baby. Sara called for the middle grade paediatrician, did the cord pH and informed the Special Care Baby Unit (SCBU) while staying in the background. The baby was eventually transferred to the SCBU. It is questionable whether the junior doctor would have done what Sarah did and thus Sara perhaps provided more assistance to the midwives than a doctor would have done. This case shocked all those present, but Sara maintained a calm demeanor and did not take over any of the midwife's jobs.

The MPs stand back, they do what needs to be done but they do not try to take over from the midwife, as Sara's actions and comments during the ventouse delivery highlight, 'there's too many people in here, I'll wait outside'. The midwives like to be the ones who are seen as being in charge of their births and jealously guard this, even after a course of action has been decided and they are no longer the ones with the ultimate responsibility for the woman (see Phase one, section 4.4.1). The MPs are keen that the midwives retain their position and do not put themselves in competition with them, as the midwives perhaps feel insecure about their authority over the delivery when it has been handed over to the MP or obstetrician.

5.5 Integration with obstetricians

The third theme is the integration with obstetricians. Two sub-categories were grouped together in relation to this theme: constraints of the MP role and equality with obstetricians.

5.5.1 Constraints of the MP role

A disadvantage of MP posts is that they have the potential to increase the workload of middle-grade doctors. MPs are currently unable to prescribe medication and they are not trained to deal with medical or surgical issues, so they must refer more frequently to middle grades than would junior doctors who have the necessary experience and knowledge and who are able to prescribe, as the following scenario shows. Ann became concerned about a client who was asthmatic, wheezing and becoming distressed. Ann paged the middle grade, who wanted to give a verbal order for medication, but Ann insisted that he needed to examine the woman. After he saw her, he ordered a nebuliser but forgot to prescribe the nebuliser and had to get back up from bed and return to the ward to do so. This caused obvious tension between Ann and the doctor. As Ann commented, this is a difficult situation to deal with:

> ...when you have to deal with something that is not just obstetrics, we are not medically trained so we don't know how to deal with these problems and I would have to wake the middle grade and they wouldn't be happy with that. (Ann)

Referrals to other specialities should be made by middle grades, after they have assessed the patient and deemed the referral necessary, but it seems that this duty has been delegated, perhaps inappropriately, to junior medical staff. These referrals cannot be made by MPs, and this limitation sometimes caused problems. It appeared that referrals were often made to avoid the middle grades having to get up to see patients during the night. This was exemplified in the following situation, which was managed by Sara and a middle grade. Sara saw a woman and asked for details about abdominal pain and a history of vomiting, she examined the woman, and found the abdomen to be soft, with no obvious pain, and so after the examination and reading the case notes, she decided the middle-grade doctor needed to see her. When she phoned the middle grade, he complained: 'Where is the junior doctor? They can refer to a surgeon.' Sara stated, 'She needs to be seen by a middle grade.' He reluctantly agreed to see the client, but when he attended the ward, he was obviously not happy about being called and was abrupt with Sara; nonetheless, when he saw the client, he decided a referral was not necessary.

Lyn informed the researcher that the middle grade obstetricians have not got used to working a shift system, and stay up all day in the hope they will have a quiet night, as this quote from a middle grade when speaking to Lyn highlights: 'I'm going to my room now, I hope you don't disturb me.' This was said in a half-joking manner, but the message was clear, she did not want to be awakened during the night. Doctor's attitudes to working shifts rather than on-calls is going to be challenged by these new roles, as they are likely to be called more often due to the limitations in the scope of care the MPs can provide.

> I think the only resentment there has been, has been from the middle grades and I think they see it as a... not a threat, but they see that they are going to have to do more work and they have said to me, 'I have worked to get to where I am and I don't want to be called to do an SHO's job,' and I said to them, 'Well you are doing shifts now and it doesn't matter what you do, you are being paid to work.' (Sara)

The MPs were aware that obstetricians might try and pressure them to undertake inappropriate duties, but they felt that they were able to deal with such situations as they occurred:

> I suppose it is inappropriate if they want us to cover gynae by day and sometimes they do, but I won't do it; they know the deal I either do theatre or do labour ward, because by day I think women coming to the pre-admission clinic have underlying conditions and I think they need to be seen by a doctor. I don't think gynae by day is our remit, unless we have further training. (Ann)

This may become a potential problem, because even though the MPs have some expertise in obstetrics and gynaecology, if women develop any other medical conditions the MPs need medical assistance. Perhaps there is a need for further training if these new roles are to be successful. Currently, though there are university courses available for nurse practitioners there are no specific courses available for MPs. The issues of referring to other specialities and the limitations in MPs rights to prescribe medication also need to be addressed.

5.5.2 Equality with obstetricians

The MPs have a different relationship with obstetricians than with midwives. The MPs are accepted as part of the medical team and their conversations seemed to be on a different level, in that they were more personal. They related to each other much better and it seemed that the MPs had more in common with them, as they experienced similar issues and had roughly equivalent responsibilities. The MPs seemed to make a conscious effort to become part of the medical team, which appeared to be a successful strategy and allowed them to become accepted:

> I've really tried hard, I've cut my ties and gone with the doctors.... And I have to be honest, it's nice to see the way the doctors are with us, they are quite happy to leave us in and do more, they know our limitations as far as prescribing and things go and anything that might come in with a medical problem, they are more than happy to help, it's, 'Oh, give me a shout if you need me,' so it is very good. (Ann)

The existence of MPs provide an opportunity to bring midwives and obstetricians closer together and the MPs have made a conscious effort to be accommodating regarding changing shifts or covering the on-call rotas:

> I think it's going to improve the relationship between midwives and doctors... I think they see us as an asset to covering, when somebody is off on study leave or something... (Sara)

The MPs felt that they have received support and encouragement from the obstetricians to develop and learn new skills:

> I feel I have had good support; I've managed to establish a good working relationship with the registrars, so hopefully they will continue to give me the support that I need. (Ann)

In addition, the MPs saw their role as using their skills to assist middle grades and support junior doctors. This reciprocal relationship was perceived as being beneficial to both groups:

> You can support junior doctors, with their clinical skills, but to be there for the middle grade as well, an accomplice for them, with regards surgery and procedures in theatre and the labour ward. (Lyn)

It was noticed that the obstetricians employ the same techniques that MPs use with midwives, when they have to tell the MPs what to do. They appear to be friendly and they encourage the MPs to do things without actually telling them what to do. The MPs were aware of this, but seemed happy to accept it. There was always the impression that the MPs were comparing themselves to doctors, to ensure that they were good enough. Ann told me about the advice she was given by one of the junior doctors, which she had been told as a medical student. This advice seemed to give her more confidence and make her more relaxed about making decisions:

> Look at them [patients]; are they going to die in the next hour? No? Are they going to die in the next 24 hours? No? Then relax and don't get too worked up about it.

In addition to clinical work, this acceptance extended to teaching and attending medical staff meetings, which can cause difficulties for MPs, who are also expected to be involved in similar activities with the midwifery team.

> I think they [doctors] want us to be involved in a lot more than we are able to, because they want to be inclusive, it is expected that we attend the teaching sessions and meetings and... we haven't had to fight to do anything the SHOs do, if we want to, it has been there for us, and that has been from day one here. (Sara)

Even though the obstetricians have given up aspects of their role to MPs, it was perceived that there was still a need to be cautious and establish boundaries, to ensure that the MP role is not exploited to meet the needs of the obstetricians. These roles have the potential to ease workloads for obstetricians, but the risk of placing unacceptable demands on MPs also has to be considered.

> The burnout, it's predominantly nights isn't it and I was thinking to myself, how long could I keep it up, I don't know, the days and the nights in the same week is a big stressor and I know the idea was to reduce the doctors' hours by night and they brought us in to help them out, but how long you can keep it up I don't know...Yeah, because the day jobs (audit, policy development, clinical

> teaching) are really interesting, I'm finding that really challenging, but at the same time you are aware of the fatigue that will come with it.
> (Ann)

The MPs have a better relationship with the obstetricians than the midwives have. This perhaps results from them sharing the same responsibilities and problems. However, it was noticeable that the MPs worked hard to develop and maintain the relationship. The establishment of the MP role has the potential to bring midwives and obstetricians closer together and their relationship is reciprocal in that they support and teach each other aspects of their own professional role. It appears that the MP role is distinct from midwifery and obstetrics, but combines positive aspects of both. The obstetricians were keen to involve the MPs in their meetings and teaching sessions and share aspects of their work. There was, however, an awareness of the need for MPs to set boundaries regarding how much time they could spend undertaking these activities and what types of obstetric work they were prepared to undertake.

5.6 Developing practice

The fourth theme concerns the commitment of the MPs to developing and improving practice. Two sub-categories were grouped together in relation to this theme: developing MPs' practice and encouraging the development of midwifery practice.

5.6.1 Developing MPs' practice

The MPs discussed the need to move out of their 'comfort zone' and use their full range of skills to undertake the challenges of taking on their new role. Ann reflected on her practice and commented that although she appears confident, she still questions what she is doing and the decisions she makes. She feels that she has learnt a great deal since taking up her post: 'When you do this job you have to think more, to stretch yourself and think of all the possibilities.' She stated that she still feels nervous about some of the decisions she has to make, but feels that gaining more experience will improve things. The challenge of developing skills may be what is required to improve morale and keep midwives within the profession, but it is questionable whether all midwives want to further develop their role.

> I think I've got to a stage in my career where I just felt like, if I don't do something different then I'm leaving midwifery, I just felt I was getting very bored, and thinking about this, it is a very challenging, motivating role and you think, 'Oh God, can I do this?' and then you look at people like Sara who has been doing it for longer than me, then I think well, in a year's time, perhaps I'll stand back and feel as confident as she does. (Ann)

Previously, if midwives wanted a promotion, they had to move into management or education and there was little prestige or financial reward for remaining in the clinical area. It was felt that MP roles could change that situation:

> You can have promotion and stay in the clinical area, 'cos promotion has always been outside the clinical area. (Lyn)

MPs have also considered the possibility of extending their role even further. With appropriate training, it was seen that it would be possible to incorporate more obstetric procedures into the role, which would allow them to work in a more senior capacity in the clinical field.

> I mean, I think I'm clever doing this job; it opens so many doors, doesn't it? What other job would have so much training put in place? I don't know what it is going to be like. Will they let us progress from here? I think it is such a promising thing; the doors could open really, if we were there hands- on, then I think you would have a skilled practitioner on site, who could talk to the woman and help her. (Ann)

It was asserted that further development of these posts might influence medical training opportunities for midwives, who in the future may be able to fast-track into obstetrics.

> I think it will probably develop and I think now there is a fast-track course for mature students into medicine in [name of university], and I do wonder if in time they will fast-track into specialities... and I think the way it is going with the hospital by night scheme, and there is a shortage and there is going to be a problem in recruiting, so I think our sort of roles may evolve and they may fast-track. (Sara)

Obstetrics and gynaecology have been accepted by medical professionals as a combination of specialties dealing with all aspects of women's reproductive health. The MPs expressed the view that their posts retain the essence of midwifery, even

though the gynaecological aspect of their work moves them away from maternity care. It was noted, however, that the majority of gynaecological patients admitted by night were in fact pregnant.

> I see it as being across the boundaries of obstetrics and midwifery, you are in the middle, so I think in the future it's going to bring the two professions closer together... it's the gynae side that's extra, but I've enjoyed it; it's something I really enjoy... Although you are not actually hands-on delivering, you are influencing outcomes, not just in labour but from early pregnancy, so yeah, I think it is still midwifery. (Sara)

The importance of appropriate support was noted as being a necessary factor, if these posts were to be successful in moving MPs' scope of care into other areas:

> I think these roles can only improve things for midwifery... but I think it will be influenced by the support they get from managers and medical staff, you need that support. (Lyn)

One of the main comments the MPs made about the difference between the traditional midwifery role and the MPs' role was that they no longer readily hand over responsibility for care. They identified the need to deal with clinical situations themselves, only calling the middle grade when clinically indicated.

> For me the management is the relative factor here, I cannot just switch off like I would have as a midwife. This role expects me to rationalise a situation and take the lead... I am very conscious that I have to be thinking about the bigger picture at all times. (Ann)

The MPs appeared to be committed to developing and improving both the maternity services and their own knowledge and expertise. These posts were seen as allowing midwives to develop their careers while remaining in the clinical area although it was acknowledged that not all midwives would want this type of role. The view was advanced that perhaps the development of MP roles might continue and eventually provide a way for midwives to progress rapidly into the profession of obstetrics. The main differences between the midwives and MPs work was the inclusion of gynaecology into their role and their increased confidence in dealing with clinical issues without automatically referring to obstetricians. Possibly these roles are too

new to be able to fully understand the possibilities they may offer to those midwives prepared to take on the necessary responsibility.

5.6.2 Encouraging the development of midwifery practice

The MPs hoped that they would be able to help midwives develop their skills by working with them and acting as role models. There was a keenness to help midwives become more decisive and develop to their full potential. It was also felt that the MP role could help midwives promote and maintain normality. If midwives referred less frequently to obstetricians, then unnecessary interventions might be avoided, as there is a tendency for obstetricians to feel they have to do something when they are called, even when it might be better simply to sit back and observe the situation.

> Well I think the role is one of support for midwives in their decision-making, in the planning and implementation of care, in supporting them in normality... Yes, as I say, you can decide when to intervene, you can be in the room with the midwife and keep it normal for as long as possible, so you are retaining normality. (Lyn)

The MPs felt that they had a supporting role in maintaining normality. It was felt that they should not take over from the midwives, but should offer support and give them the confidence to think for themselves. The MPs felt that this could only strengthen midwives' autonomy and help retain midwives within maternity services.

> If there is something edging on the abnormal, the midwives will say, 'What do you think?', and I can say, 'Well, let's leave it half an hour', and in that time things may have rectified themselves and things may be progressing. Whereas before, there would have been intervention at that point and it's giving midwives the opportunity to think for themselves... and I think they will then have more job satisfaction and that will help to retain staff. (Sara)

The MPs emphasised the fact that midwives have always had high-level skills and have influenced obstetricians' decision-making skills, but have stopped short of taking responsibility for the actual decision-making:

> Sometimes if you look at a midwife and an SHO, the midwife is actually feeding the SHO that information. They don't feed the information to us

because we know the same as them; we are just confirming what they already know. (Sara)

The issue of midwives having to be experts in all areas of midwifery was discussed as a possible reason why midwives want to leave the profession. The MPs thought that perhaps it might be better if midwives worked in an area in which they felt comfortable and were allowed to develop confidence and expertise.

Labour ward isn't for everyone, I know it sounds awful 'cos you think everyone has to do everything, but sometimes they don't want to do it, they can be utilised to promote the profession elsewhere... you know we integrated everyone, didn't we, and a lot of people couldn't cope with the stress and there are lots of specialities in midwifery now... and it's thinking, would they prefer to work in one area rather than being moved, which they can't cope with? (Ann)

Generally, MPs saw their role as maintaining the core aspects of midwifery care, while helping midwives develop their skills and maintain normality. The MPs felt that their success could be measured by how much the midwives working with them developed their practice.

I think this role maintains the core aspects, you protect normality and I think this role is to be a support for midwives. Sometimes you have to intervene, but not criticise – just gently let them know if there is a problem with what they are doing. But I would see this role as helping them to develop their skills and confidence. (Lyn)

There was a degree of optimism expressed by the MPs, that they were starting to influence midwives' decision-making skills – although it was acknowledged that the midwives were still reluctant to take on additional responsibility. Notwithstanding the benefits of developing the MP role, the negative impact of this development on midwifery staffing levels was also considered. MP roles were developed to meet the shortfall in the number of junior doctors. However, these new posts were taken from the current number of midwifery posts available in Wales, without any provision for planning additional midwifery training places. This was done at a time when a number of maternity units were already experiencing acute staffing shortages.

It takes senior midwives out of the clinical area, although you are still clinical you are not there as the G grade, and I think these roles have happened across Wales at the same time and it has taken a lot of senior staff away from the

> clinical areas, and I think in some places clinical services are floundering because of it, there is nothing to fill the gap, to back-fill. (Sara)

The MPs felt that they had an important role in helping midwives to develop their skills and confidence in practising autonomously. They were also committed to helping midwives to maintain normality during childbirth, but were keen to do this without taking over responsibility for care from the midwives. There was concern that midwives should be supported and praised for the their work, if retention issues within midwifery services were to be addressed. However, the development of these posts further impacted on the problems of retention of midwives by moving experienced midwives into these new posts.

The findings of this Phase of the study indicate that MPs are able to combine positive aspects of midwifery and obstetrics, to provide acceptable and safe care. Furthermore, they are committed to developing and improving both the maternity services and their own knowledge and expertise, but there are a number of constraints to the MPs' role, such as the limitations on their ability to prescribe medicines, which need to be addressed if these new roles are to be successful.

CHAPTER SIX – PHASE THREE RESULTS

Nothing is so conductive to greatness of mind as the ability to subject each element of our experience in life to methodical and truthful examination, always at the same time using this scrutiny as a means to reflect.
(Marcus Aurelius, Translated by Hammond, 2006:21)

6.1 Introduction

Phase three of this study used semi-structured interviews with clients, midwives and obstetricians and was carried out in the same maternity unit as Phase two. This aspect of the study allowed a clearer picture to be developed about the MP role and its impact on the midwives and obstetricians working in the unit. In Phase three I was able to explore these issues in more detail by asking participants about this subject and exploring further what I had seen and heard during Phases one and two. Fifteen categories emerged from Phase three data and were grouped under four themes (see Appendix 12 for the table outlining the stages of coding). The four themes identified were: perception of roles, consequences for the midwives, consequences for the obstetricians and the effectiveness of the MP role. The findings of this Phase are presented in the form of narrative description and quotes from participants.

6.2 Perception of roles

The first theme discussed is the perception of professional roles in maternity services. The three major sub-categories grouped under this theme are: perceptions about midwives, perceptions about obstetricians and perceptions about MPs. All the clients were asked about the roles of the midwife, obstetrician and MP, while the midwives and obstetricians were asked to describe the roles of midwife and MP.

6.2.1 Perceptions about midwives

Five obstetricians and 10 clients spoke on this subject. In addition, four midwives discussed the ambiguity of the midwives' role when dealing with women at high-risk of developing complications, where the obstetrician is the lead professional in charge of the woman's care. Although some clients and obstetricians had a reasonable understanding of the midwives' role, it was concerning that many did not, as illustrated by this quote: 'Well, they look after you and make sure you are all right, um, I don't know, they just look after you and the baby' (Client 8). In spite of this, they all had a positive image of the midwives who had cared for them. 'I've been really impressed, yeah, well, impressed because they were so good' (Client 7).

The clients were unclear about the image of midwives portrayed by the media, and none of them felt that a clear picture of the midwives' role was provided: 'It is all different to the reality here, isn't it? It [the image of midwives in the media] doesn't relate to what the midwives do here' (Client 5). After having been through the childbirth process, some had a clearer idea about midwives' work: 'No, I don't think I really knew what they did. I knew they looked after patients and they took care of them' (Client 6).

Some obstetricians understood the midwives' role, while others were less clear and did not seem to understand all that it entailed, however, the development of MP posts seems to be helping their understanding in this regard:

> I had in my mind that the role of the midwife was giving a helping hand rather than being in the forefront and taking part in a lot of activities which doctors are doing, but as times are changing and as the MPs are coming forward, probably lots of the workload is being shared by the midwife as well, but yeah, initially I thought the role of the midwife was just to observe and tell us things. (Obstetrician 4)

Midwives were very clear about the responsibilities of their role when caring for women at low risk of complications, however, when it came to describing their role in caring for women at high obstetric risk, they expressed conflicting views. It was asserted by some midwives that women at high risk of developing obstetric

complications were the remit of obstetricians, and midwives should hand over all responsibility. Generally, midwives seemed happy with this situation and did not appear to want to develop their skills further, so as to work in a more autonomous way when caring for such women:

> They shouldn't be interfering with the abnormal, that's where the consultants come in... and whatever the midwives do is overseen by the obstetrician, as they become the lead carer for that woman. In that instance the midwife takes a back seat. (Midwife 3)

However, other midwives contended that their role was to support all women in labour, regardless of their risk status, though it was unclear what part midwives should play when obstetricians were the lead carer. This confusion about the midwives' role was commented on by a number of midwives, who stated that if they are to be seen as professionals, they should be able to offer more than just support to women experiencing complications: 'If you look at it from a medical perspective, they may see we have more to give than just psychological support' (Midwife 5). Nonetheless, it was acknowledged that some midwives are keen to hand over responsibility to obstetricians and are content to work more as obstetric nurses, carrying out obstetricians' instructions.

> Some midwives call a doctor to the ward and say, "Well, it's over to you now." They don't say, "Well, I think this is the problem and we should do this, do you agree?" (Midwife 4)

This category indicates that the midwives who participated in Phase one of the study were correct in thinking that their role was not fully understood, however, the clients interviewed in this Phase viewed them in a positive light, which conflicts with the image they thought they had (see sections 4.5.1, 4.5.2).

6.2.2 Perceptions about obstetricians

Clients were asked about the role of the doctor in maternity care. All were positive about the obstetricians with whom they had had contact – although their comments about them were brief, which implies that they had not really considered their role to

any great extent. However, some clients understood the distinction between the obstetric and midwifery role and when it would be necessary for obstetricians to take over responsibility for care: 'I would say they had more responsibility in the decision-making, like the midwife can go so far then the doctor has to take over' (Client 3). It was noted that the junior doctors were more visible than the consultants. This may be understandable, in that consultants have more commitments, but is nevertheless undesirable, as junior doctors are in training posts and will not have the expertise of a fully trained obstetrician. Even though junior doctors were more visible than consultants, clients still felt that it was midwives who provided the practical and supportive aspects of care and who assisted obstetricians.

> The role of the obstetrician seems completely different from [that of] the midwife, the midwife seems to be a lot more hands-on caring. When I came in I was screaming my head off and they dealt with that, and I was saying, 'Get me someone now" and losing my temper, and they prepared everything ready for the doctor, it seemed really distinct, they did the ground work, ready for the doctor to come in. (Client 7)

Doctors were perceived as having responsibility for dealing with investigations, making diagnoses and delegating work to midwives regarding the plan of care to be undertaken:

> I've only ever really seen a doctor when things have gone wrong and it's been a case of, "These are the symptoms, this is the diagnosis and back to the midwife."(Client 1)

Generally, clients perceived obstetricians positively and saw them as being responsible for the decision-making and care management. This category does not appear to support the views expressed by some of the midwives during Phase one that they were able to practise autonomously (see section 4.5.1). However, it was comparable with the findings of Phase one in that clients felt that midwives were a constant presence and were more responsible for providing the more caring and supportive aspects of care (see section 4.3.2).

6.2.3 Perceptions about MPs

All midwives, clients and obstetricians discussed their understanding of the MP role. Midwives and obstetricians had a basic understanding of the MPs' role, although the midwives felt that it took them some time to fully understand what the role entailed. Some midwives had concerns about whether clients would accept the MP role, as this midwife explains:

> I don't think women understand the role of the midwife yet, let alone that of the MP, they may see it as negative 'cos they rely on the doctor to sort things out, they may feel cheated in a way by not seeing a doctor. (Midwife 5)

Some clients had a good understanding of the MP role and its possible benefits for the obstetricians:

> I would say she works at a junior doctor level and perhaps takes midwifery to a further level when caring for pregnant mums and mums who are delivering, and eases the role of the junior doctors. (Client 3)

However, on further questioning, it became clear that Client 3 had more insight into the role, as she worked as a paediatric nurse in a unit where paediatric nurse practitioners were employed. It was noted, however, that some other clients shared this understanding and were aware that MPs were midwives who had taken on additional responsibilities to provide some aspects of care that had previously been undertaken by obstetricians.

Clients generally understood that there were distinctions between different midwifery roles, but the part played by MPs was nonetheless not fully understood. It was apparent that all of the clients accepted being seen by MPs and did not object to them taking on aspects of the doctors' role. This seemed to reflect more their unquestioning acceptance of care provided by a health care professional, rather than an understanding of the implications of high-risk care being managed by a midwife: 'Yeah, so many people have come to see me, I don't know who is who' (Client 8). This acceptance may have been assisted by the fact that the MPs were perceived as being friendly and helpful:

> I have no problem with it, 'cos she is just as good in my eyes. I think she was lovely, she was thorough in her work and she went around it in the right way, if you know what I mean. (Client 2)

It seemed that as long as clients were receiving satisfactory care, it did not matter who provided it. When women are in active labour, they understandably care more about having their needs met than about who is caring for them, they just want someone who appears to be confident and competent, whom they can trust to look after their best interests when they are unable to do this for themselves, as outlined in Phases one and two (see section 4.3.1 and 5.3.1):

> No I didn't question who was caring for me, but I was pretty hysterical... I would have had Mickey Mouse as long as he gave me an epidural [laughing], I would have accepted anybody. (Client 7)

The view was expressed that the midwives' role had changed and extended so much that the advent of MPs was just a natural progression for midwifery. The caring aspect of their role also came across as being important to women, as was the impression they gave of having plenty of time to spend with them. This appears to support the findings of Phase two (see sections 5.3.1 and 5.3.2).

Five obstetricians and five midwives felt that there had been a degree of hostility to the introduction of the MP role. Many obstetric respondents raised the issue of locum doctors' concerns about MPs. Locums are generally unfamiliar with the maternity unit and rely heavily on the junior doctors for support, they did not seem to feel that the MPs could provide the same level of support:

> I know there have been occasions where we have had a locum and that person is not sure about his role in relation to them. (Obstetrician 1)

A number of the obstetricians mistakenly felt that they would be accountable for the actions of MPs, and still viewed themselves as being 'in charge' of them:

> They feel [that] if something goes wrong with the management of a case, then they [locum doctors] are going to be questioned and they therefore want to oversee the midwife, so they have got to re-think their role in that they are the same and that they are a colleague. (Obstetrician 3)

Interestingly, some doctors commented on the divide between MPs and other midwives:

> I have seen that there is a little bit of resentment from other midwives as well. They have started dividing themselves between the MPs and the regular midwives, so I don't know if it will broaden the rift or if they are going to see them as their friend. (Obstetrician 4)

This may relate to the ambiguity felt by midwives about the MP role outlined in Phase one results (see section 4.4.3) but this was not noted during Phase two. However, all of the clinical midwives interviewed made reference to the issue that some MPs had difficulty in not seeing themselves as being responsible for the running of the unit. This seemed to be seen with a degree of humour and an understanding of the difficulty midwives find in stepping back from situations and letting others take control.

> I think sometimes they find it a bit difficult to forget that they're not the midwife in charge anymore *[laughing]* and that's the only thing, and that will be sorted out in time and people will be put in their place and told, 'No, that's my job to do, not yours.' (Midwife 1)

The issue of midwives expecting the MPs to undertake midwifery duties was both real and apparent to the medical staff. This was also observed during Phase two (see section 5.4.2):

> Often the midwives don't understand the role of the MPs and if they are, sat at the desk, as the SHO would do, writing the notes and the buzzer goes off in another room and they don't rush to answer it! And at the end of the day they wouldn't ask the SHO to do it, and that has been since they started and it hasn't got much better. Perhaps their uniform has to change so [that] they don't look like midwives. (Obstetrician 3)

Ten midwives and four obstetricians commented that they did not view the MP role as being either a midwifery role or an obstetric role, but saw it as a separate role that helped to bridge the differences between the two professions. Initially, midwives felt that being an MP was a midwifery role, but this seems to be changing and the MPs are being seen as being separate, and their work as having no effect on the work of the rest of the midwives. As the role has developed to meet service needs, it has moved

away from traditional midwifery practice, the midwives questioned whether the MPs should continue to have the word 'midwife' in their title:

> I feel it is less of a midwifery role and more of a medical role than I thought it was going to be. I think it is sort of going its separate way and it is becoming a distinct role... Perhaps it isn't right to call them MPs now, 'cos I don't know [if] that is what they are. (Midwife 1)

Obstetricians also expressed this view: 'I don't think it [the MP role] has really affected the midwives' role, I think they are working in a different role to the ordinary midwives' (Obstetrician 6).

The issue of the MP role being distinct, but comprising aspects of both the midwifery and obstetric roles was also noted during Phase two (see sections 5.3.1, 5.3.2, 5.4.2 and 5.5.2). However, there was concern that the role of MP may eventually develop completely into a medical role. There was also concern that this may be exacerbated by the fact that there may be more prestige attached to the medical aspect of their work:

> Sadly, I think you may have some who would be happy to wander around with a stethoscope around their neck and be mini-doctors, rather than maxi-midwives. It could be seen as being more prestigious, you know, doing a medical role. (Midwife 2)

These concerns were also expressed during Phase one (see section 4.4.3).

MPs are a relatively new development and they were introduced without any guidance on the specific requirements of their role, other than undertaking some of the tasks previously carried out by junior doctors. As a result of this, it was apparent that these posts have been interpreted differently in different maternity units, therefore, it may be too early to fully understand how they will develop.

> It is different, depending in which Trust you work.... Initially, it appeared the role was going to be that of an SHO, but as individuals we bring to the role what we think the role should entail. So it is early days, but I think it is still developing and we won't see the end product of the role for quite some time. (Midwife 5)

Notwithstanding this, the 'bridging' aspect of their role was perceived as being positive for both professions: 'They have an enhanced role, they seem to be a bit of a go-between, between the midwives and the doctors' (Midwife 8). The medical staff saw this intermediary role as being positive, and they felt that it would bring about a greater understanding of both roles.

> I think MPs bridge the gap between midwives and obstetricians, as they do a bit of both jobs. I think they will bring midwives and obstetricians together. (Obstetrician 2)

This was also noted during Phase two (see sections 5.5.2, 5.6.1 and 5.6.2). The role was viewed positively by middle-grade obstetricians, who felt that it had extended beyond what would be expected of a junior doctor, and that the MPs worked in ways different from midwives:

> If an MP calls me from [the] labour ward I know there is a problem, whereas if a junior SHO calls me, it is much the same as a junior midwife calling me. I think it is a completely different role to the midwife and it's a completely different role to the SHO. (Obstetrician 3)

An issue which caused particular concern amongst obstetricians was the way MPs might extend their role in the future. One doctor commented that the MPs could eventually extend their role even further, by improving both their decision-making and technical skills to a point where fewer obstetricians would be required:

> I think in years to come, they will take the role of the experienced SHO, so ideally they will not only be able to make decisions, but also be able to fulfil them, so they will be able to do ventouse deliveries, fetal blood sampling, that sort of thing, which means that in the future, there will not be as many doctors on the shop floor. (Obstetrician 3)

In this section some difficulties were commented on between midwives and MPs, which were not noted during Phase two. However, generally the findings are similar to those of Phase two.

6.3 The consequences of MPs for the midwives

The second of the themes discussed is the consequences for the midwives. Four major sub-categories were grouped together in relation to this theme: support for midwives, depletion of midwifery staffing levels, future development for the midwives, and increased expectations of midwives.

6.3.1 Support for midwives

Nine midwives, one client and four obstetricians mentioned the issue of MPs providing support to other midwives. The good relationship between midwives and MPs was visible to clients. This client described the attitude of the MP and the midwife towards each other and their agreement on the best way to proceed with the management of her care:

> It was all quite informal. It was a case of, well, "I can't make this decision so I will get the MP", and they both agreed, the midwife knew what she wanted to do and the MP agreed and that was it. (Client 1)

The feeling that they were part of a cohesive team was shared by midwives and it was felt that MPs had more knowledge than junior doctors and offered more support to the clients:

> They have got more idea than the junior doctors anyway, so you do feel you are getting more support from them than you would have done from a junior doctor. We used to bypass the junior doctors. (Midwife 9)

This seems to reflect the good team working noted during Phase two (see section 5.4.1). However, this differs from the views expressed by some obstetricians during this Phase of the study (see section 6.2.3).

Midwives felt that the MPs helped them maintain normality, however, MPs need to protect themselves from being used as another 'pair of hands', if they are to ensure the success of their role. A number of obstetricians felt that MP posts were of benefit in

that they offered support and additional training opportunities for junior midwives. The midwives agreed with this view, although they acknowledged the fact that MPs could not spend all of their time on the labour ward:

> I think they have got so much to give for normalising midwifery, that the juniors [midwives] can learn from, and because they are going to be here seven nights a week they could be used to nurture our juniors. They are always complaining that they haven't got enough support, and I think they could be used in that supporting role. (Midwife 1)

The midwives also used the expertise of the MPs to help and advise them when they were undertaking practice - updating courses. This support was also noted during Phase two (see section 5.6.2). The fact that the MPs were being trained as supervisors of midwives was also seen as a positive development.

6.3.2 Depletion of midwifery staffing levels

One midwife and three obstetricians commented on the fact that if midwives moved into these new MP roles, there would be a depletion of senior experienced midwives, which may result in further recruitment issues for the profession. As this midwife pointed out, midwives were being employed to solve the problems of obstetricians:

> It's a waste of midwives, when we can't afford a waste of midwives. There is a shortage of midwives in the country and we can't afford to lose good midwives and I think that is sad, 'cos we are making a gap in our own profession. (Midwife 1)

Obstetricians also felt that there was a need to retain experienced traditional midwives, to ensure the provision of safe maternity care. It was felt that if there were not enough experienced midwives available, the work of doctors would be made more difficult.

> I am concerned that in developing these roles, the cream of the midwifery staffing is taken away and this can cause problems in staffing labour ward. You need experienced midwives on labour ward who can spot problems and call the doctor early on. You don't mind coming to sort problems out, but it is easier if things can be done early. (Obstetrician 2)

There was concern that financial incentives might tempt midwives into becoming MPs when they may not really want to take on the role, which may result in ineffective care provision. This would be a waste of resources at a time when there is a shortage of midwives, and it was felt that this issue had not been considered in previous workforce plans:

> Well, the worry is that because of financial incentives or career progression that the core midwifery workforce will be depleted, you find everybody wants to be an MP and we already have a recruitment crisis and are short of midwives. So there must be a back-up strategy. (Obstetrician 7)

The impact of MP roles on the retention of clinical midwives within maternity services and the possible resultant staffing shortages was also mentioned by the MPs during Phase two (see section 5.6.2).

6.3.3 Future development for the midwives

Four clients, one obstetrician and eight midwives spoke about the future development of the midwives. Generally, clients thought this was a positive development that could improve recruitment into midwifery, although the need for appropriate financial rewards for these posts was highlighted:

> Better career structure as well, I would have thought. There is a shortage of midwives, perhaps if there was a better structure, you would have more women turning to midwifery. The financial rewards should come with it, though. (Client 1)

The MP role was perceived by midwives as providing career progression, while still allowing midwives to stay in the clinical area and retain their clinical skills. However, there was concern that these roles might be used as 'stepping stones' to other roles:

> Everyone gets to a point in their career where they have to develop, whether that means management, teaching or becoming an MP. I think it will be good for clients, but whether it is just a stepping stone for midwives, we will go on to learn in the future. (Midwife 5)

The midwives felt reassured that the development of MP roles would not have been allowed, unless all aspects of this extension of the midwives' role had been investigated and approved by their regulatory body, the NMC. Although midwives felt that these roles had not changed traditional midwifery practice for the majority of midwives, it was acknowledged that these posts had raised the profile of midwifery, as they appeared to have a degree of prestige attached to them. It was also recognised that midwifery is rather insular and that other health care staff outside of the profession do not understand the role, as discussed during Phase one (see sections 4.5.1 and 4.5.2). The MP role was seen as having the ability to increase the level of knowledge about the complexity of the midwives' role: 'I don't know if the midwives' role *per se* has changed, because that will always be the same, but I think it raises the profile of midwives' (Midwife 8).

One midwife remarked that midwives had always played a part in teaching doctors, and that by embracing these additional skills, midwives could be recognised for their enhanced expertise and become more effective advocates for women.

> At the end of the day, we have always taught the doctors what to do and never got the credit for it, so yes, I feel we should be taking more control, because we're the mothers' advocate. (Midwife 9)

The issue of midwives being advocates for women was also discussed during Phase one, but was not noted during Phase two (see sections 4.5.1 and 5.4.2). However, it was noted that the risks of taking on the medical role and model of care needed to be guarded against, there was concern that midwives must not lose the essence of their role, just to fill a service provision gap left by the reduction in junior doctors' hours. This concern was also voiced by the MPs during Phase two (see section 5.5.2).

6.3.4 Increased expectations of midwives

Nine midwives and three obstetricians discussed the fact that this extension of the midwives' role might result in an expectation that all midwives should take on the additional responsibilities embraced by MPs. Many concerns were highlighted regarding the level of responsibility and autonomy the MP role entailed, and whether

all midwives would want this. The view was expressed that some midwives were only too happy to refer complicated cases, because they did not want the responsibility of managing high-risk care:

> I think when they [the midwives] call a doctor, they think, "Oh, it's their problem now," and it's not, it's everybody's problem. It's passing the buck really and I think they see the MPs as someone to pass the buck to, and [they] shouldn't be. (Midwife 4)

Midwives' reluctance to embrace responsibility was also commented on and noted during Phase two (see section 5.4.2). Several midwives and obstetricians made strong comments that this role was more suitable for midwives who have relevant experience and who were confident and could cope with the responsibility. It was felt that this would require a midwife who would not be afraid of taking on more responsibility for decision-making and working as an autonomous practitioner:

> It carries an extra responsibility and you would have to say, 'I want to take on that responsibility to be a MP.' Probably some midwives, I have found from past experience, would not want to take up that extra role, because if you miss out on certain things, in the same way as if I did, obviously you would be held accountable and I think that would put some people off taking this role. That person needs that sort of personality and the in-built confidence to decide to go out and do it. (Obstetrician 1)

This issue was also noted in Phase two (see section 5.4.2). While others felt that all midwives should develop and extend their skills and work in the same way as MPs currently do, as this would improve care provision. Some midwives, however, expressed concern that midwives might take on too many new responsibilities without support, which could result in them becoming too medicalised and in a dilution of their midwifery skills:

> With our registration we need to consider whether we are capable of doing what we are asked to do and whether we have the correct training to do it. We will be going over to the medical side of things, and is that really a good thing? Who is going to be the advocate for the woman? We may become 'Jack of all trades, master of none'. (Midwife 8)

6.4 The consequences of MPs for the obstetricians

The third theme concerns the consequences for the obstetricians in the unit. Three major sub-categories were grouped together in relation to this, these were: delegation of aspects of the obstetric role, the affect on the workload of obstetric middle grades, and the clinical training of junior doctors.

6.4.1 Delegation of aspects of the obstetric role

Two of the midwives and all of the obstetricians commented that the development of MP posts was necessary in meeting the requirements to reduce junior doctors' working hours. It was generally agreed that the issue of doctors working long hours throughout the day and night was unsafe and unsustainable:

> With less medical hours available, people are going to have to fill in the gaps, and I think they [MPs] are really the only people who can fill the gaps, unless consultants do 24/7 and do night shifts and I can't see that happening soon! (Obstetrician 3).

However, one midwife commented that midwives should not take on this extra responsibility, just because it suits obstetricians to relinquish aspects of their role. Midwives felt that they should take on these posts only if it benefits midwives and their clients:

> Our medical colleagues are facing a huge dilemma with the European Directive and as midwives we are highly skilled and there are roles we can take on, but we shouldn't be taking them on just because medical staff are relinquishing them. (Midwife 2)

The issue of obstetricians continuing to care for women with uncomplicated pregnancies was noted as being inappropriate and unsustainable. It was felt that in the future, obstetricians will specialise in different aspects of obstetrics and that the generalist obstetrician will no longer exist. As a consequence, changes to the midwives' role were seen as inevitable.

> There will be consultants with various specialities to deal with different categories of patients. It is all about sub-specialties now, because you find for instance that there are obstetricians who only see patients with, say, haematology problems. (Obstetrician 1)

While the necessity for changing the way care is delivered was accepted, there was concern that both midwives and obstetricians should not lose sight of the fact that traditional midwives will continue to form the bulk of the midwifery workforce. However, it was felt that the MP role would become established and would become part of normal obstetric care. It appears that obstetricians have considered the alternatives to MP roles and found that these are not viable:

> If you didn't have MPs, you would need large numbers of junior doctors and with the apparent halt in the expansion of consultant posts, there would be no career progression. How could they all get to the top? (Obstetrician 6)

6.4.2 Effect on the workload of obstetric middle grades

Ten midwives and seven obstetricians discussed this topic. It was generally felt by the midwives that the MPs' workload was at least the same as that of the junior doctors. References were made to the fact that as a result of their approachability, they may have an increased workload.

> I don't think their workload is any less than the SHO. In fact, they may be called more, because they are more approachable. But also because they are more experienced, you wouldn't phone an SHO and ask their advice on a CTG tracing, but you would phone an MP. (Midwife 6)

This approachability may also be influenced by the fact that the MPs are present in the unit throughout the night, rather than in the on-call rooms. In the past, middle grades have been accustomed to working on-calls and sleeping through the night, unless called upon for assistance. The change to a shift system has taken a long time to be accepted by the middle grades, some of whom still felt that they should be able to spend most of the night sleeping in the on-call room. Although the middle grades' resentment at being called by MPs appeared to have lessened since the fieldwork for Phase two was conducted (see section 5.5.1), it was not clear whether this was

because they accepted that they should be working throughout the night or whether the MPs had gained more skills and confidence and were calling them less.

> I think that is altering and as they are getting to know more about what they are doing, I think the registrar's work is lessening. When they were new, I think it was increased by a vast amount. When the junior doctors come here, they are as green as grass, whereas the MPs have got all their expertise to start with, so I think the middle grades' workload is lessening because of it. (Midwife 1)

Concern was expressed that MPs might not have the depth of knowledge to deal with issues not related to obstetrics and gynaecology, and that this could limit extensions to their role, as discussed in Phase two results (see section 5.5.1). It seems that they have enough expertise to cover the workload of junior doctors, but they do not have the knowledge that would be expected of a middle grade, which may restrict them to a junior level within the obstetric speciality.

> Compared to a first on-call, they do lots and lots, but covering the middle grades' work, no, because you are only appointed as a middle grade when you have a very good understanding of the anatomy and physiology of the body. You can't do it with just a superficial knowledge and it is difficult to train a person in six months or 12 months when the doctors work for 10 years to get that. (Obstetrician 4)

It was noted that other specialities, such as medicine and surgery, have been slower in accepting MP roles and that the systems regarding referrals have not changed in light of their development. It seems that there still needs to be a change of culture if MP posts are going to be effective. Currently, if an MP feels a referral needs to be made, she has to ask a doctor to do this:

> The other hurdle is acceptance by other specialities for referrals from MPs, some are still of the view that a referral should come via a doctor if it is being made to a doctor. (Obstetrician 7)

This was also noted during Phase two (see section 5.5.1).

The lack of prescribing rights can increase the work of middle grades, although now that they are working a shift-based rather than an on-call system, they should be available to attend the unit to prescribe medication (see Phase two results, section

5.5.1). This limitation of the MP role might be rectified by changes in the regulations surrounding midwives' ability to prescribe. In the future the MPs will become more established in the role and gain more confidence, and they will not be changing units every four months, as junior doctors do. Therefore, they are likely to be of more support to the middle grade, as they will eventually have gained more experience than junior doctors.

> The issue of prescribing is obviously an issue and until it is resolved, it will add a bit of extra work for the middle grades, because they have got to sign prescriptions. But barring the first part of their care when they are gaining the skills and experience and are getting more confident, in the long term, they are bound to be more of a help and support to the middle grades than the junior doctors. (Obstetrician 7)

In addition, MPs also have responsibility for auditing, teaching and policy development, making them more effective members of staff than junior doctors. It was noted that the initial fears that middle grades would see a steep rise in their workload were unfounded:

> In the beginning, some of the middle grades felt that they would be called all the time. But this hasn't been the case, and as they get more experienced, they will be like the SHOs who have been around for a few years and they will be called even less. (Obstetrician 6)

6.4.3 The clinical training of junior doctors

Three midwives and seven obstetricians commented on this subject. Some of the medical staff had very strong views about the negative impact MPs had on the clinical experience available to the junior doctors. With the current arrangements, junior doctors are not expected to deal with cases by night. It was felt that previously, when junior doctors worked night duty, they would have a first-hand perspective of how complicated cases should be managed. With the new system, however, they are missing out on this experience, and when they become middle grades, they may lack the necessary expertise to deal with such cases. This may result in consultants being called more frequently for assistance, and it could eventually result in them having to be resident in the unit during their on-calls. Reference was made to the fact that this

might affect recruitment in units where junior doctors do not work at night, however, the expectations regarding the experience to be gained when working at night may differ from the reality, as this middle grade points out:

> Personally, if I've got a third or a fourth degree tear and it's 4:30 in the morning, I don't have the patience to sit and let the SHO do it, and there are quite a few times with an emergency delivery that I won't let the SHO do it because there is fetal compromise. So they are not really missing out on that kind of thing. (Obstetrician 3)

One midwife felt that midwives and MPs worked at a higher level than junior doctors, and that the limited expertise of junior doctors in dealing with obstetric emergencies meant their involvement was restricted and inappropriate. It was noted that in the past, they had used emergency situations to gain experience when in reality they should not have been expected to play such a crucial role in the management of critical care provision.

> If you have a problem on a delivery unit, you almost bypass the junior doctor, because if there is something you can't sort out at your level, you know you need a registrar or above. It is one of the things that has been cited in the confidential enquiries, that the appropriate person hasn't been called. But at the same time, there has got to be some form of training package for people to learn. (Midwife 2)

Although all of the junior doctors interviewed felt that they should be included on the night rota, other factors were identified by more senior obstetricians as having an impact on the depletion of the experience gained by junior doctors. The view was expressed that the pattern of clinical training has been restricted, which reduces junior doctors' chances of acquiring and maintaining obstetric skills. This senior obstetrician felt that there were other alternatives available for training during the day that could be further developed:

> I think there are enough opportunities to get experience in the day and enough training opportunities for them, but this is being looked at nationally. It seems already that the middle grades need a lot of handholding. Years ago, the consultant was the last person you wanted on the labour ward, because they were never there, now it's the other way around. The consultant is called for things that they [middle grades] would never even have thought of mentioning to you a few years ago. (Obstetrician 6)

Another senior obstetrician expressed the view that there does not appear to be an overall strategic plan to address the issue of the development of the MPs' role, including its impact on the training of the junior doctors:

> There may be strategies available, but what I'm not sure about is whether there is an overarching plan to look at the maternity services in totality. If somebody is designing a certain care pattern in one area, we have to be careful of what impact it will have in another area, and if there are any negatives, [to] see how they can be rectified. And that is the difference between looking at something from your car and looking down from a helicopter, I don't get the impression that somebody has got in the helicopter and is looking at everything from the top. (Obstetrician 7)

6.5 Effectiveness of the MP role

The fourth of the themes discussed is the effectiveness of the MP role. Four major sub-categories grouped together in relation to this are the effect on client care, communication, the gynaecological aspect of the role and training and monitoring.

6.5.1 The effect on client care

Nine clients, seven obstetricians and eight midwives commented on the safety of the care provided by MPs. All of the clients who discussed this subject felt that MPs were competent in providing care and were reassured by their confidence:

> Oh yeah, she does know her job well, I felt confident in her treating me, 'cos she was confident and she explained as she was doing things. She made me feel more relaxed and it's nicer to have a woman rather than a man *[laughing]*... Just the comfort and you know you will be well looked after, so there is no excuse to make a fuss and say you want a doctor. (Client 2)

Obstetricians, who felt that the MPs had progressed from working as traditional midwives and had developed obstetric skills in identifying complications, viewed the effectiveness of the MP role positively.

> I find they are more confident midwives and the things I would be looking out for as a medic, they are looking for them straight away, rather than you having

> to point it out, that is not to say that the traditional midwife is not looking out for those things, but you can see that they have that mindset, that they are looking out for things that I look out for. (Obstetrician 1)

This seems to confirm the findings from Phase two that the MP role combines positive aspects of both the midwives and obstetricians' role (see sections 5.3.1, 5.3.2, 5.4.2 and 5.5.2). However, the midwives had more concerns and made several references to the importance of MPs, knowing their limitations and working within their competencies. There were concerns that the MPs needed to have a clear vision of how they saw their role developing. This midwife illustrated the importance of developing her role in a way that benefits clients:

> As a profession, we have just got to be very clear about what we want to take on for the sake of that woman and having faster, efficient care. (Midwife 2).

This reluctance to extend the boundaries of practice may reflect midwives' general reluctance to take full responsibility and accountability for care provision, as observed during Phase two results (see section 5.4.2).

One of the benefits mentioned about these roles was that the MPs worked in the same way as the midwives, in that they looked at the client in a holistic way. Many of the respondents from all groups mentioned that because of their years of training and experience as midwives, the MPs were more competent than the junior doctors. This client explained how, in her experience, the midwives had often noted when medical staff had not made the right decision and had ensured that the correct action would be taken:

> When I've been with a doctor before, they listen to what the midwives say anyway or the midwives will say, "Oh, I'm not quite happy", and have gone back to see the doctor and something else has been decided. (Client 1)

Nine midwives and five obstetricians discussed the issue of the impact of the MP role on intervention levels during childbirth. There were varying opinions on this issue. Some midwives felt strongly that the MPs were committed to reducing unnecessary interventions, such as acceleration of labour and operative delivery, whilst still ensuring safe care provision:

> I know one MP in particular will really push for the normal and will even argue with the registrar about it and suggest things. They wouldn't put women at risk, but they would look for a normal outcome. (Midwife 6)

Other midwives were less sure about their success in ensuring normality and reducing medicalisation, and they were disappointed that there had been no obvious change in client care or intervention rates: 'Well, I would like to think they [MPs}have resulted in less intervention, but I don't think they have' (Midwife 4). The views and philosophy of individual MPs were seen as being important factors that influenced whether women's care was kept as normal as possible.

> If you have a midwife who is fundamentally based in normality, but has now taken on the role of complicated midwifery, then you are likely to look at the woman as normal. But traditionally, if midwives have wanted to take on the role of advanced midwifery and look at medicalised care, then I would imagine they have baggage about medicalisation. (Midwife 5)

Interestingly, all of the MPs employed in the unit were perceived to be in support of normality. However, they had not had any impact on the rates of caesarean sections or accelerated labours, as the birth statistics from the maternity unit showed that there had been no substantial change in intervention levels since the MPs had been in post – though it was perhaps too soon to tell, as they had been in post for only a short time. The obstetricians held the view that there had been no improvement in client care or on intervention levels during childbirth, however, they were satisfied that the establishment of the posts had not had a detrimental effect on care provision:

> I really don't think the standard of care has gone down for the worse, but I can't say that there has been any dramatic improvement, perhaps it is too early to say. (Obstetrician 4)

However, in spite of the disappointment that has come with the MP role not resulting in reduced interventions, it was recognised that the issues surrounding the medicalisation of childbirth are complicated, and that many factors would have to change if this were to be reduced:

> It is too early to judge, but the experience from the units who have had MPs for longer than us is that it hasn't materialised. It is a very compound issue, because it is not just the level of support they can offer, it is a long process, which

> sometimes begins even before the woman gets pregnant. It is a bit about the litigation issue as well. So it hasn't fulfilled the expectation that with the extra support of an experienced MP, that they will instil more confidence into the midwife and the mum and reduce interventions. (Obstetrician 7)

In addition, some obstetricians held the view that the intervention levels in maternity care were increasing before the MPs came into post, and that this had been influenced by a lack of skilled middle-grade obstetricians. The increase in litigation cases in maternity services may have resulted in them becoming more nervous about risk-taking:

> I don't think it [the MP role] has affected interventions. The section rate was going up long before they came into post and it has continued to rise. But this has probably had more to do with the lack of expertise of the middle grades, who are a bit too cautious and section anything. (Obstetrician 6)

6.5.2 Communication

Eight clients, four obstetricians and eight midwives discussed the issue of communication and commented positively about the communication skills of the MPs. It was reported that the MPs understood the anxieties felt by clients and spent time reassuring them:

> I had to have a cyst [ovarian] removed when I was 16 weeks pregnant and she came to see me after that, 'cos I was wondering after the operation, was the baby going to survive. She made me more relaxed and it was nice, 'cos I could understand, it was more relaxing after she had been, it was lovely. (Client 2)

It was noted that the MPs spent time understanding women's personalities and assessing what type of communication would best meet their needs. This was seen as being necessary, to find out how women cope with childbirth and to ascertain what type of care best suits their personality. This corroborates the findings from Phase two results (see section 5.3.2). Clients made several references to the fact that the midwives communicated in a more reassuring way than the doctors, and it appeared that MPs used their midwifery skills when speaking to clients (see Phase two results, section 5.3.1). This highlighted the MPs' ability to build a rapport very quickly with

women and their families and to reassure women and their partners, helping to allay their fears and calm them down during difficult situations:

> The way they are and the way they speak, they explain more than the doctors do. The doctors don't explain enough, but with the MPs, they will go over things if you are concerned or if you've got any problems. (Client 6)

The clients expressed the view that the relationship between midwives and MPs was relaxed and informal. The view was expressed that they were able to anticipate women's needs better than doctors (see Phase two, section 5.3).

> It seemed very informal... It was like talking to a midwife, but she dealt with the clinical situation, so it was different... The doctor did pop in to see me and introduced himself, but it was as if his timing was all wrong and then he went again, and I thought that was really bizarre. Whereas a midwife would kind of know when you are in labour when it is right to talk to you and when you want to be left alone. (Client 1)

The midwives confirmed the views of the clients about the MPs' communication skills: 'They talk to them very much as a midwife, not with the SHO hat on, no, they speak to them exactly as a midwife might' (Midwife 7). Reference was also made to the fact that MPs have been generally recruited from the locality where they are employed, and that this assisted with the understanding of the local culture and knowing what women wanted from the service. The fact that they were all female was also seen as being advantageous to understanding women's needs.

> I think patient care will improve, because they've got a good bedside manner and I think, oh, this should be off tape now *[laughing]*, they can speak to our clientele and that speaks volumes, they are women they understand what our patients needs are, they are local people and they know what our patients expect from us and I think they can alter their vocabulary to suit the moment. (Midwife 1)

The midwives felt that it was a benefit that the MPs had not been trained according to the medical model of care. This helped the MPs see the client not just in terms of their clinical condition, but as a whole person with emotional and social as well as physical needs, in order to provide appropriate holistic care, as noted during Phase two results (see section 5.3.2):

> We do come from a different model from the medical staff. Hopefully they will think more about social issues than our medical staff will, so I hope it will be a more holistic package of care. (Midwife 2)

A number of the obstetricians agreed that the MPs communicated in the same way as the midwives, and they acknowledged that doctors had the scope to improve their communication skills.

> You hate to say that your colleagues are not very good at communicating, but I don't think it is an integral part of doctors' training that they can communicate well with patients. I think that the patients will tell them [MPs] things they wouldn't necessarily tell us, or they may be less anxious, [and] more honest than if we came along. People are more succinct with us and slightly nervous as well. (Obstetrician 3)

The view was expressed that MPs' communication skills helped prepare women for any possible interventions, which made the middle grades' jobs easier. In addition, they were able to communicate clinical information to the middle grades in an efficient manner, which ensured that they were made aware of all the relevant clinical details:

> They are reassuring these ladies, so by the time you come to see them they have prepared them for what will happen... if they called me out to see a patient, they would highlight those important points right from the very start and I wouldn't have to go looking for them. The report I get from them is more informative, more detailed and more specific [regarding] what has to be addressed straight away, and that makes life very easy for myself [sic] as I can just pick up from where they have left off. (Obstetrician 1)

6.5.3 Gynaecological aspect of the role

Nine midwives and four obstetricians discussed this subject, the maternity clients were not asked about this subject. The issue of MPs providing care for gynaecology patients invoked mixed reactions. Some commented that with additional support, it would be reasonable for midwives to extend their role and work as MPs who cover gynaecology services. However, others questioned whether midwives had the depth of knowledge required, though it was recognised that many junior doctors did not appear

to have an in-depth knowledge of gynaecology. Some midwives felt that they would not want to consider undertaking the role of MP, if it involved gynaecology.

> I am not sure about gynae, obviously, if they have worked on gynae and have got the experience, then that's a different matter, but if you are diagnosing, it's a different matter again. They've got the expertise in midwifery and you've got to be able to have the same expertise in gynae to be able to perform the role safely. (Midwife 8)

The issue of assisting with gynaecology surgery was also a cause of concern to some midwives:

> For basic things like bleeding, a midwife would be giving that information anyway, so I don't think it is a problem there, but as for taking it further, to say hysterectomies, I don't know if I would be comfortable with it. (Midwife 9)

Meanwhile, others felt that there was more scope for MPs to develop in gynaecology services than in midwifery:

> We have always had extended skills in midwifery because of delivering babies and being autonomous practitioners, so maybe in gynae I can see it working even more smoothly. (Midwife 2)

However, some midwives felt that with adequate preparation and training, working in gynaecology should not be a issue, especially given that they had their nursing experience and knowledge to draw upon:

> I've got no problem at all with them doing gynae. I think it is difficult for them, but as long as they are confident and have been supported and keep on being supported in their practice, I think they will do a very good job. (Midwife 4)

The medical staff members were impressed with the way the MPs had developed their knowledge of gynaecology, but felt that there was still a need for further training. However, it was felt that with time and additional experience, they would develop the necessary skills.

> When it comes to early pregnancy problems I think they are remarkable, they are absolutely fine. They are very ready to learn and see what needs to be done... Gynae, as I said, there is still a bit of learning to do there, but I don't

> think it is that much, within a short while they will have achieved that and they will take off. (Obstetrician 1)

Nonetheless, the fact that there was always a middle grade on duty to give advice reassured them that the MPs were safe in providing gynaecology services. Obstetrics and gynaecology have always been combined into one speciality, while midwifery and gynaecology nursing have always been separate. The MPs were perceived by obstetricians as being brave in taking on the responsibilities of another speciality:

> If there was a problem with an ectopic pregnancy or something like that, then I think that is where the problem would lie with the general public or people who don't know the system and who might say, 'How can a midwife deal with a surgical problem when she has had no surgical training?' They must be really nervous when they go down to casualty because it is a minefield, when you are a specialist it is a minefield, it is the equivalent of a general surgeon walking onto the labour ward. It frightens them to death. (Obstetrician 3)

However, the senior obstetricians felt the way gynaecology services were now delivered meant that it was not such an insurmountable challenge:

> I don't see a problem with them looking after gynae patients. Out of hours, it is really about babysitting the elective patients and dealing with the odd emergency. Most of the urgent cases are diverted to the day unit now anyway. (Obstetrician 6)

6.5.4 Training and monitoring

Seven midwives and seven obstetricians discussed the matter of the training and monitoring of MPs. It was generally felt that they had received enough training to undertake their role and would continue to develop their skills. The supportive relationship among MPs was seen as being helpful in ensuring that their knowledge was kept up-to-date, as they were all happy to share any information they had gained with each other, as well as with other midwives:

> I think they are very supportive of each other and if they had problems or if they wanted to extend their knowledge, they would do it through each other, as that network is set up already. (Midwife 7)

The lack of nationally agreed-upon criteria for evaluating the competence of MPs raised concerns about their position and protection should litigation cases arise:

> The NMC standards just say that the role is extended as long as you are qualified to do that role, but I would hate to see the day when there will be something in court, because nobody has said what is appropriate training. (Midwife 2)

The lack of appropriate courses for MPs was also raised, currently, there are courses for nurse practitioners and courses aimed at obstetricians and gynaecologists, but there have been no courses specifically designed to meet the needs of this new type of health care worker.

> We need to look at training very early in their career rather than doing it after a complaint or litigation suit.... I think the role has started very quickly, we have given as much training as we could have, but I think they need courses before they get to these levels. (Midwife 5)

The issue of training was also discussed by medical staff, as was the lack of agreed updating. This is strictly defined for medical and midwifery staff, but there are no specific updating requirements for this new role.

> Locally, we didn't rush them and were very conscious not to let them loose unless they themselves felt confident to go ahead. Generally, I think the system was introduced without the necessary agreements for the training and monitoring. (Obstetrician 7)

Interestingly, some obstetricians felt that the role involved fewer challenges than MPs would have experienced in their midwifery posts: 'There are just a few scenarios in obs and gynae, and if you know how to deal with them, then I don't think it matters' (Obstetrician 2). However, it was acknowledged that the lack of in-depth training in other specialities had not been addressed in the MPs' initial training, although the view was expressed that this training did not appear to have significantly benefited junior doctors:

> They [the MPs] certainly have enough training to carry out their role on the antenatal, labour ward and postnatal ward. I think that the only training they might be slightly deficient in is in general surgical and medical skills, which is

probably not worse than some of the junior SHOs who come through. (Obstetrician 3)

The results of this aspect of the study generally support the findings of Phases one and two. They also demonstrate that the midwives are not generally being adversely affected by the development of MP roles, however, this development may have some consequences for the obstetricians. The results of this Phase also highlight the lack of preparation, appropriate training and agreed competencies for this new role.

The themes from the three Phases of the study were brought together and explored to develop organising concepts (see Appendix 13), which form the structure of the Discussion Chapter.

CHAPTER SEVEN – DISCUSSION

Change is the law of life. And those who look only to the past or present are certain to miss the future.
(John F. Kennedy, unpublished speech, Frankfurt, June 25, 1963)

7.1 Introduction and brief overview of the study so far

This study has explored the MP role and its impact on midwives and obstetricians in a maternity unit in Wales, with the aim of revealing the differing perspectives about this subject.

> In reflexive research, the writing of the research report and the representation of the data are concerned not with persuading the reader to accept the findings, but with a reflection on the relationship between the text and other texts.
> (Freshwater and Rolfe, 2001: 535).

I am a manager, clinician and novice researcher. During this research study I tried to be constantly attuned to how my values and beliefs might impact on my actions and interpretation of events observed or heard. I was also aware of the potential for an imbalance of power and endeavoured to avoid using my position in a way that could exploit others. I began this study with the view that midwives risked losing the more holistic caring aspect of their role by taking on medicalised aspects of the obstetric role perhaps becoming mere technicians undertaking specific tasks discarded by the obstetricians. However, the picture that emerged as the study progressed was not as I had anticipated.

In considering the research aim, the following subject areas were selected as being relevant and were examined in the literature review chapter: regulation and the contemporary role of the midwife, autonomy and inter-professional relations, and the extension of traditional allied health professional, midwifery and nursing roles. After an examination of the relevant literature a gap was identified regarding the development of the MP role. The methodological literature was also reviewed in order to develop the study design. As there has been no research into this new role, a

qualitative, exploratory approach was chosen, while the use of ethnography allowed not only for the exploration of the MP role, but also for consideration of its impact on midwives and obstetricians in the research setting. This qualitative study employed a focused ethnographic approach to study the culture of midwifery in a setting where midwives work as MPs. This method allows for appropriate data to answer the aim of the study, which is: To explore the role of MP and its impact on midwives and obstetricians in a maternity unit in Wales.

It is acknowledged that this study can present only the researcher's perceptions of the truth about MPs – as there are always multiple truths – and objectivity and accepted truths are always situated, as an account from someone can only be, in some temporal context (Borbasi *et al.*, 2005). The role of MP was developed as a matter of expediency, in order to meet the recommendations of UK health policy documents. However, the current study has provided insights and added to the body of knowledge regarding this exciting development. The study would seem to show that this extension of midwifery practice has resulted in a new and distinct health care worker who is neither a traditional midwife nor a doctor, and yet combines the positive characteristics of both, to successfully substitute for junior doctors. It seems, from all three phases of the study, that midwives in general do not perceive themselves to be negatively affected by this new role. Participants do see, however, that the MP development may have some consequences for the obstetricians. This study also found that current systems need to be adapted such as, making referrals to other specialities and prescribing, if these new roles are to reach their full potential.

The themes generated from the analysis have been explored and developed into organising concepts, which will comprise the structure of this chapter (see Appendix 13). This chapter discusses the findings of the study, comparing them with relevant literature. The chapter begins with a discussion about the role of the midwife and the opportunities and constraints that have shaped it, while considering the divergence between the tentative traditionalists and the confident progressives. The significance of the MP role for the midwives and obstetricians is then explored and the distinct role of MP is considered, along with its possible impact on the midwives and obstetricians. The strengths and weaknesses of the study are discussed and finally, the contribution this thesis has made to the policy and practice literature is outlined.

7.2 Maternal carers

The current study has found that traditional family roles, as defined by Nicholson (1997), were played out within the realm of maternity services. The obstetricians take the paternal role, assuming ultimate power and responsibility for the family. Midwives are the maternal carers who provide care and support and ensure the safety of the family, they show deference to the paternal figure, while assuming control over the children in order to protect their well-being. Within this paradigm, clients are assigned the role of child, whose welfare needs to be ensured by the 'parents' or health professionals.

The current study reveals that midwives have a clear understanding of the essential functions of their role (see Box Five) and which aspects they would not want to lose. However, the midwives in this study, with the exception of those working in birth centres, appeared to be unhappy with the constraints of their working lives, though there was little enthusiasm for extending their skills so as to take on the additional responsibilities of MPs.

Box Five: Midwives' perceptions of the essential aspects of their role

Provides safe care.
Is confident in manner and actions.
Develops a trusting relationship with women.
Is supportive of women and their birth partners.
Takes control of the situation during labour.
Acts as an advocate for women.

Midwives hold the view that women need to see that their midwife can provide safe care and that she/he is confident in her/his manner and actions. The midwives in the current study felt that an important part of the work of a midwife is to take control of the situation during labour and act as an advocate for women. Despite the fact that such advocacy might be justified – as childbirth is a life-changing event (Raphael-Leff, 2001) – the midwives did not seem to understand that taking control of women's decisions and choices in labour might sometimes be inappropriate. A study by Bluff and Holloway (1994) found that women followed midwives' advice and did not

challenge their decisions, even when these differed from what the women had originally wanted. The study found that this might be because they trusted the midwife and wanted her to take control, however, it also found that many women wanted to be involved in choosing the type of care they received, but they did not know how to communicate this to the midwives. Lavender *et al.* (1999) also found that women wanted to maintain control and to be involved in making decisions about their care. Having said this, the midwives in the focus groups in the current study did not appear to understand the power dynamic between them and clients, and how such a dynamic can impact on women's compliance with midwives' suggestions.

Midwifery practice has been extended to provide support for birth partners (Somers-Smith, 1999, Eames, 2004), but the midwives held the view that supporting both the woman and her partner takes the emphasis away from the woman at a time when she needs to be calm and feel supported. The issue of women employing the services of doulas to assist with this matter was explored, but the midwives were of the view that rather than helping the midwife support the woman and her partner, a doula might interfere with the relationship between the midwife and the woman. Generally speaking, the midwives did not want any intrusion or interference when they were providing care during childbirth, and they had not appreciated that women might want the support of someone with whom they already had a trusting relationship.

This attitude resembles the 'medical gaze', described by Foucault (1973), of doctors over the provision of health care, where patients must accept the medicalisation of their health and hand themselves over to the care and decision-making of doctors. This is in line with the medical model of care, which perceives childbearing women as patients from whom compliance can be expected. The medical model of care can be described as mechanistic (in that the body is seen as a machine which can be repaired) as well as reductionist (in that only the part that is malfunctioning is given attention). This approach to care provision is in contrast to the midwifery model of care, which is humanist and holistic and stresses the need for women and their families to be involved in decision-making and choices regarding the type of care they receive (Bryar, 1995, O'Connor, 2002) (see 2.2.2).

In the past healthcare policy in the UK has supported and indeed encouraged the medicalisation of childbirth, which has resulted in the medical model of care becoming accepted in maternity services. The midwives who participated in this study felt that this situation is now changing, as the recommendations of healthcare policy documents in recent years (see section 2.3.1) have encouraged midwifery-led care and extended midwifery roles such as MPs.

Generally, the midwives in this study perceived themselves as being autonomous practitioners who try to provide a midwifery model of care. However, this study identified some uncertainty about their commitment to this, as their views and actions indicate an acceptance of deferring to medical staff for decision-making and a degree of compliance with the medical model of care. Bryar (1995) suggested that midwives' approach to care could be placed at any point along a continuum between the midwifery and medical models of care. In the current study the findings suggest that generally, the midwives' approach to care provision was more towards the medical model of care. This approach was more prevalent in hospital midwives, rather than those who worked in birth centres.

The contradiction between how the midwives perceived themselves and their underlying beliefs and actions implies that they state what they feel should be their position, but that they fail to put this into action. This may be one possible reason why the recommendations of healthcare policy documents such as *Changing Childbirth* (1993) have not reduced the medicalisation of childbirth. The reliance upon and compliance with the decisions of obstetricians suggests that the majority of midwives may not want to accept the additional responsibilities of working as MPs. Hunter (2004) identified conflicting ideologies between community midwives who espoused woman centred care and hospital midwives who prioritised meeting service needs. The current study has identified that such conflicting ideologies exist within the majority of the individual midwives, resulting in similar dissatisfaction with midwifery practice noted by Hunter. If midwives are to improve their job satisfaction there is a need to put their beliefs into practice, by accepting more autonomous roles such as those of MPs, or accept that these beliefs do not fit with their current requirements.

7.3 Glorying in oppression

Midwives who are dissatisfied with their practice, but who are reluctant to take on a more autonomous role, can be described as tentative traditionalists, who retreat into the safety of referring and deferring to obstetricians and who 'glorify their oppression' by portraying the limitations of their role as positive characteristics. In reality, this stance puts them in a weakened position in the provision of maternity services and may place the continuation of their profession at risk, at a time when health care policy documents are recommending the development and extension of healthcare roles.

Generally, the midwives in the study appear to have accepted that their role should be limited to providing only the normal aspects of care during low-risk childbirth and that obstetricians alone possess the knowledge to manage care when complications arise. In fact, there is no legislative limit to the activities midwives can perform, so long as they have received appropriate training and have the skills needed to carry out the procedure at hand (Dimond, 1999). It is not just midwives who are now extending and developing their role, other healthcare workers, such as nurses and AHPs are also taking on aspects of the medical role. Indeed nurse practitioners have been successfully developing their role for some years (Venning *et al.*, 2000, Sakr *et al.*, 2003).

A number of midwives in this study felt that they had more autonomy than nurses. However, others acknowledged that they were not able to practice autonomously and that it was nurses who were taking steps to alter their practice in ways, which increase their level of autonomy. This may suggest that there may not be a great deal of impact upon midwives resulting from the development of the MP role, as only a minority of midwives will want to, or indeed feel able to, develop their careers in this way. This suggests that the number of midwives working as MPs is likely to remain low. However, this study also exposes the considerable pressure on newly qualified midwives, mainly in the hospital setting, to 'fit in' with the characteristics of the tentative traditionalists. This may reflect the conflicting ideologies of practice outlined by Hunter (2004). Experienced midwives can resent and feel threatened by newly qualified midwives who are keen to take on more autonomous practice and

responsibility, resulting in midwives who experience stress and low morale – stressors that may result in an exacerbation of recruitment and retention issues (Ball *et al.*, 2002). Furthermore, in the current study, the bureaucracy of the NHS has been shown to be responsible for placing additional pressure on midwives to conform.

In the current study only a minority of midwives can be described as confident progressives who are prepared to embrace change and the extended role of the midwife. Change is inevitable in any profession and the development of MP posts should allow career progression for individuals and improve the profile of midwives. These posts ensure recognition of midwifery skills and allow midwives to practise with a higher level of autonomy, but the tentative traditionalists in the current study felt there was a danger that MPs might not be able to maintain the midwifery model of care in their practice and therefore move toward a medical model of care. However, the results of this study demonstrate that this concern is unsubstantiated. Though the development of MP posts could result in all midwives being expected to work in ways consistent with this progressive trend, the findings of this study indicate that the majority of midwives are tentative traditionalists, while confident progressives are in the minority.

In this study, midwives were unhappy with a number of aspects of their working lives. This dissatisfaction has been identified in other studies (Kirkham, 1999, Ball *et al.*, 2002, Hunter, 2004, Lavender, 2004, Lindberg *et al.*, 2005), and this dissatisfaction is likely to result from a number of factors. Most importantly, the medicalisation of childbirth has been successful. Systems have been developed that place the GP as the first point of contact and the hospital obstetrician as the lead carer for the majority of women. By contrast, in Holland, for example, the midwife is the first point of contact for entry into maternity services, and the woman is not allocated to an obstetrician unless there is an indication (Benoit *et al.*, 2005). In allowing UK systems to develop in the way that they have, healthcare policy initiatives have resulted in midwives being left with burdensome workloads, but relatively little autonomy (Currell, 1990, Stevens, 2002, Davis-Floyd, 2005). Although this study indicates that generally midwives do not want additional autonomy, they find the current situation unacceptable, which again may result in the conflict between what they say they want and what they accept.

Doctors have also been successful in maintaining their power over the decision-making process when planning and providing care (McCallin, 2001, Blue and Fitzgerald, 2002, Combs and Steven, 2004). Allen (2000) found that though senior doctors were happy about delegating technical tasks, they had concerns about handing over aspects of their work that they regarded as central to their role, such as making the diagnosis. This may explain why midwives are reluctant to take on the responsibilities of decision-making and accountability, as these are perceived as being the domain of the hierarchically 'senior' medical staff. However, an advantage of complying with the idea that obstetricians alone have responsibility for decision-making and planning care is that midwives commonly, though perhaps inaccurately, describe themselves as autonomous practitioners, without ever having to accept full responsibility for care provision. This has been a sore point between obstetricians and midwives for some time (Fawdry, 1994).

Currie (1999) contends that midwives should be aware of factors that restrict their autonomy and the scope of their practice. The regulation of the midwifery profession, which came about in the form of the Midwives Act (1902), restricted midwifery practice to caring only for women experiencing normal childbirth (see 2.2.1). Throughout most of the 20th century, midwifery training was at certificate level. Unlike doctors, dentists and many other health professionals, midwives did not have graduate-level entry or a scientific body of knowledge on which to base their practice (Hartley, 1997, Cahill, 2001). This was compounded by the fact that most midwives originally trained as nurses, and were socialised to accept a role where they carried out the directions of doctors (Siddiqui, 1996). This may explain why the midwives in the current study feel more comfortable working as tentative traditionalists, as they believe this is all they are capable of and is what they have been socialised to accept. This fits with their concerns about MPs 'knowing their limitations', as perhaps they feel vulnerable about moving away from, what they perceive as, the safety of maintaining their current level of autonomy.

The midwives in Phase one of the current study appeared to understand the constraints imposed on their practice by obstetricians, and they stated that they were prepared to be perceived as difficult and challenging in order to change this situation and act as advocates for women. Though these characteristics were not generally

evident in Phase two of the study, they were noted among midwives who provide midwifery-led care and those who work as MPs. These two groups of midwives were entering the territory of obstetricians, which increased their status and autonomy. Marshall (2005) argues that the establishment of direct-entry midwifery degree courses has produced midwives who are better able to act as autonomous practitioners. However, it is perhaps unrealistic to expect neophytes to alter established systems, and studies have shown that newly qualified midwives are under pressure to conform to the culture in which they work (Kirkham, 1999; Ball *et al.*, 2002). Other studies, meanwhile, have shown that those midwives who are unable to conform and 'fit in' are likely to leave the profession (Begley, 1999, Begley, 2001, McIntosh, 2003, Warriner, 2003, Hunter, 2004, Davis-Floyd, 2005)).

In this study the midwives' use of language fitted more closely with the medical model of care rather than the midwifery model, for example referring to women as patients or by the type of birth they experienced e.g. 'the section from yesterday' (see field notes, night one, Appendix 9). This mechanistic language is in contrast to the woman-centred, individualised care espoused by the midwives, who perceived themselves as being the advocates for women. This type of language portrays women as being submissive and in some way deficient within the medicalised process of providing maternity care. Further examples of language that portrays women in this way include some terms used to describe obstetric complications, for instance: failure to progress and incompetent cervix. These terms imply that women are defective and in need of help from obstetricians in order to give birth (Kitzinger, 2005, Hunter, 2006).

Much to my displeasure I noted, while conducting this research study, that I used such language myself. The use of language, which fits with the medical model of care, has been so accepted that those using it are no longer aware of doing so and of the subversive way it can undermine the midwifery model of care. Equally, it may reflect a desire by midwives and obstetricians to maintain a system that puts them in a powerful central role in maternity care. This approach may also allow them to maintain some control over what remains a high risk and unpredictable life changing process. It may also be a mechanism, which helps midwives to cope with the

pressures of working within maternity services. Menzies (1960) noted the use of similar strategies in nursing care.

The fact that midwifery is a female-dominated profession may have resulted in the exploitation of midwives (Harden, 1996). Some, such as Kirkham (1999), Lavender (2004), argue that midwives have assimilated the value system of an oppressed group – for example, horizontal violence, emotional dependence, lack of self-esteem, disdain for other women, reluctance to embrace freedom and change, and alliance with the oppressor (Kuokkanen and Leino-Kilpi, 2000, Romyn, 2000). Attributes in relation to achieving emancipation in decision-making in women's health have been identified and they are equally applicable to professional emancipation in midwifery: These are 'reflection, personal knowledge, empowerment, awareness of social norms and a flexible environment' (Wittmann-Price, 2004:441). To be deemed successful they should be enacted without negative consequences.

Until recently, the recommendations of healthcare policy relating to maternity services have supported obstetricians taking the lead role in care provision. Although this is now changing, it will take time for midwives to gain equal status with obstetricians and the confidence to change from working as tentative traditionalists. Despite publications such as *Changing Childbirth* (DoH 1993) espousing midwife-led care, we have seen elsewhere in this thesis that systems were slow to be put in place to support the 'new' lead practitioner. This led to disenchantment at best and burnout at the worst for those midwives who tried to follow the government guidelines within an unaltered working environment.

In light of these factors, it is perhaps unsurprising that the midwives in the current study were concerned about knowing their limitations and accepting the need to refer care to another health care professional, even when they had more experience than the person to whom they were referring. While obstetricians continue to decide which women fall into the category of being at high risk, the majority of women will continue to be allocated to obstetric rather than midwifery-led care. As Kennedy (1981) points out, it is those who define 'illness' and 'normality' who maintain power over health care provision:

> Illness is an indeterminate concept, the product of social, political and moral values, which as we have seen fluctuate... If illness is a judgement, the practice of medicine can be understood in terms of power. He who makes the judgement wields the power. (Kennedy, 1981:7)

There are a number of demands on midwives to extend their practice, both to take on extra clinical skills and to have more input into the public health agenda. So it is perhaps understandable that midwives are cautious of extending their role to the detriment of its core aspects. Indeed, any new developments should be evidence-based rather than a 'knee jerk' reaction to gaps in service provision. Moreover, if all clinical midwives undertake the enhanced skills inherent in the MP role, there might be difficulties in ensuring that their basic skills are maintained and updated, with the risk that, as with junior doctors in the past, there would be a keenness for midwives to intervene just to maintain their expertise. This issue needs to be explored before considering any developments that would result in the general extension of midwifery practice. If all midwives undertook such extended practices it would result in the need for additional funding to pay for them to attend appropriate courses and to ensure more midwives were employed to cover the extra study leave, which would be required, on an ongoing basis. Therefore it may be more realistic from a financial perspective for only a few midwives in each maternity unit to develop such enhanced skills.

If midwives are not going to extend their role to provide individualised care for women when complications occur, there is a need to identify why *midwives* are required at all in the process of care provision for women with complications. Documents such as *The Future Role of Consultants* (RCOG, 2005) and *Safer Childbirth* (RCOG, 2007) recommend an expansion in the number of obstetric consultants, to ensure their increased presence on labour wards. If these proposals are carried out in full there may be less need for midwives in high-risk obstetrics as the greater number of consultants could be more cheaply supported by unqualified staff workers such as MSWs. This may result in a further increase in the medicalisation of childbirth, with women being supported and cared for by untrained staff. All of which may impact upon the quality of maternity care provision.

It is generally thought that midwives in the UK have not been able to effect change, in either the ways in which maternity services are delivered or in the position of midwives within maternity services (Hillier, 2003). It is therefore understandable that this perceived powerlessness has made them more cautious about undertaking any proposed changes to maternity service delivery impacting their workload. Obstetricians continue to be successful in protecting their place in the provision of maternity care (RCOG and RCM, 1999, RCOG, 2005), and unless midwives also become proactive in safeguarding their position, they may continue to find themselves in a marginalised situation compared to obstetricians. Midwives need to take advantage of recent healthcare policy initiatives to develop strategies to empower both themselves and the women to whom they provide care.

> By widespread consent, 'empowerment' is achieved when people acquire the ability to control, or at least significantly influence the personal, political, economic and social forces by which their life trajectory would otherwise be buffeted. (Bauman, 2005:124)

Unless more midwives are prepared to embrace the characteristics of the confident progressives and challenge existing hierarchies, they will continue to lack the power to enact change, as Lawless (2006:444) argues: 'We need to be far less polite and more subversive in how we take our true and lived experiences about birth to obstetric power and to state power.' Though this argument may be justified, it seems that by suggesting midwives should be subversive, Lawless (2006) continues to adhere to the rules of the 'doctor-nurse game' (Stein, 1967), rather than using the assertive approach of an autonomous practitioner. Despite concerns over further extensions to midwives' sphere of practice – by insisting that their work should encompass only normality and not extend beyond this – midwives put their future at risk. Whether midwives feel ready for change or not, recent policy initiatives such as *Midwifery 2020* (DoH, 2008) are likely to result in the position and status of midwives changing, ensuring that they are able to practise in ways which most effectively benefit users of maternity services.

7.4 Conflict and consequences resulting from MP roles

This section discusses the ambiguity surrounding midwives' responsibilities and considers the impact of MP posts on the recruitment of midwives and delegation of aspects of the midwives' role.

7.4.1 Conflict between traditionalists and progressives

Generally, the midwives who participated in this study were sensitive about others taking over aspects of the care they provide, though most did not want to take decisions about the management of care when complications arose. Even experienced midwives are happy to ask MPs for advice, but they can seem unconcerned about the management of care after they have made the referral and feel that they can criticise those to whom they refer, for being conscientious. If midwives are to be taken seriously as professionals, there is a need for them to take responsibility and accountability for decision-making (Fawdry, 1994, Symon, 1996, Lewis, 1998). The ambiguity regarding their expertise and lack of readiness to accept autonomy and responsibility can cause difficulties in the relationship between midwives and obstetricians. This could also potentially cause difficulties between tentative traditionalists and confident progressives such as MPs (Fawdry, 1994, Brownlee *et al.*, 1996, Dyas and Burr, 2003).

Midwives' sensitivity about the level of autonomy in their role appears to have resulted in the use of the 'doctor-nurse game', as described by Stein (1967) (see 2.4.2). Stein *et al.* (1990) contended that, at the time of publication, its use was declining, however, this study found that the use of the 'doctor-nurse game' is still prevalent. The midwives (mainly in phase three) were ambivalent about the role of the MP and their main concern was that MPs still felt they were in charge of the management of the unit, though this was not evident in Phase two of the current study. Midwives also felt insecure about their authority over the provision of care when it has been handed over to MPs or obstetricians.

This study found that MPs are committed to supporting the development of midwives' practice, but they are keen for midwives to continue to feel they have retained their position of authority over care provision, even when the woman they are caring for has been referred to MPs or obstetricians. Though this approach may be well meant it perpetuates a somewhat false view of the situation, as the midwife inevitably relinquishes responsibility for the overall management of the woman's care after the obstetrician has been called. It does, however, draw attention to the conflict between the midwives' view of themselves as autonomous practitioners and the reality of obstetricians taking over responsibility for care provision when complications are noted. The midwives' sensitivity about others being 'in charge', may result from the conflict between how midwives perceive themselves and the reality of the restrictions to their practice.

There is an expectation that MPs should help out by undertaking midwifery duties during busy periods, but this is not possible, as MPs have different responsibilities and areas of practice (see Appendix 3). Lumsden (2005) found that midwives who had extended their role to undertake neonatal examinations were often pressured to perform this examination for babies in other areas. It was reported that they had to develop assertiveness skills in deciding when it was appropriate to agree to perform these extra neonatal examinations. Similarly, MPs need to develop their assertiveness skills further, to avoid being seen as 'just another midwife' who can help out during busy times. Such a perception could result in them being used inappropriately and could affect the success of their role, perhaps causing confusion and conflict over roles and responsibilities.

Midwives (mainly in phase one) perceived that they were viewed by doctors and nurses as elitist and sometimes difficult to work with. The view was expressed that this may be the result of having to act as advocates for women to ensure they receive appropriate care, and so the midwives were not unduly concerned about their image. This attitude may be problematic when UK health policy documents, such as *Making a Difference* (DoH, 1999) and *Realising the Potential* (NAW, 1999) recommend multi-disciplinary work. If midwives are to secure and enhance their position as maternity care providers, there is a need to work collaboratively with others. In this study the midwives felt that outside of the health service, there was a lack of

understanding about the role of the midwife. They held the view that while the public appears to understand the roles of doctors and nurses, they generally do not understand what midwives' work involves and that in the media, midwives were either 'invisible' or misrepresented. The midwives recognised that their initial assumption that clients understand the midwives' role is not necessarily correct, as noted by Leach *et al.* (1998). There was, however, a degree of optimism that the image of midwives was improving and that midwives were beginning to be seen in a more positive light, especially as their visibility in the community increases. This study found no evidence for the improving perception of the midwife by either clients or by doctors.

If midwives are to claim a powerful and autonomous position in the provision of maternity care, there is a need for them to fully accept the attendant autonomy in their practice and embrace the responsibilities as well as the benefits this brings. However, it may take some time for the culture of midwifery to change to a point where the majority of midwives could be described as confident progressives, who were prepared to extend their role to work as MPs.

7.4.2 Protecting midwifery staffing levels

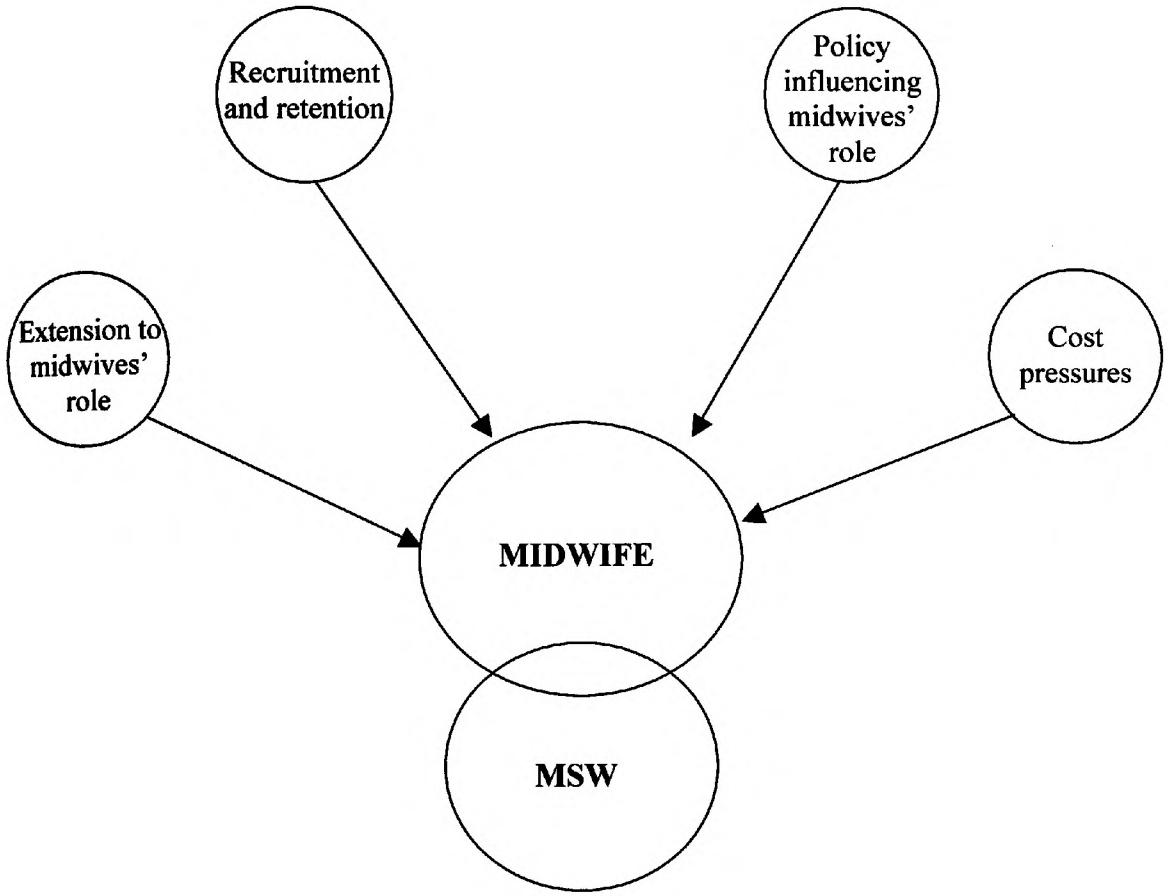
Just like other extensions to the midwives' role, MP posts were developed as a result of the urgent need to fill the gap in service provision left by reductions in junior doctors' working hours (Mitchell, 2002a, Mitchell, 2002b, NHSE, 2003). MPs were recruited from the number of midwifery posts available in Wales, without any provision for additional midwifery training places to replace those that were lost. In this study, a number of respondents felt that MPs were being exploited for the benefit of obstetricians, and it was questioned whether midwives should be developing their role to cover a shortfall in medical staffing at a time when the midwifery profession was experiencing its own recruitment and retention issues (Ball *et al.*, 2002, RCM, 2003). It was also felt that there was a need to retain experienced midwives in clinical labour ward posts, to ensure the provision of safe maternity care. On the other hand, respondents expressed the view that the development of MPs' roles had benefits in terms of recruiting and retaining midwives, as this would improve their image and

enhance career progression while still allowing midwives to stay in clinical practice. Although MP posts caused some staffing problems when they were first introduced, workforce plans have since been amended and the situation has now improved, though other issues, such as retention problems, still impact on midwifery staffing levels. This indicates a need for an overarching strategy to plan developments in the midwives' role that consider the implications for all types of midwives and all aspects of maternity services.

The midwives freely admitted that they are territorial and protective of their role and resent handing over aspects of their work. However, there was an acceptance that delegations of aspects of the midwives' role to MSWs were necessary. On occasion, the inadequate number of midwives available to provide care results in a need to delegate the work of midwives and this has now become an accepted way of providing care in Welsh hospitals (see 2.3.2). The extension of the midwives' role further – including the development of new roles, such as those of MPs – has necessitated the development and extension of MSW roles. The establishment of these posts has also been influenced by cost issues and recruitment and retention challenges in midwifery (see Figure Two). Like the development of MP posts, the introduction of MSWs was not planned prior to execution and the scope of this job has extended in response to gaps in service provision resulting from the aforementioned factors. It is therefore difficult to clearly define the MSW role in Wales, as they are continuing to evolve and are now gradually encompassing aspects of care that were previously part of midwifery practice (see Box Six).

It has been reported by the media that in England, MSWs undertake vaginal examinations, abdominal palpations and CTG monitoring, in addition to their usual work. This raises a number of concerns about the safety and appropriateness of care provided by MSWs. In Wales, the leaders of the profession and the RCM are working together to collate baseline information about the current remit of MSWs and to agree the aspects of care they should be providing.

Figure Two: Drivers for the development of the MSW role



Box Six: changing aspects of care provided by MSWs

Old Aspects of MSW Role

Attending to women's hygiene needs
Serving meals
Cleaning
Checking basic equipment
Answering phones

New Aspects of MSW Role

Breastfeeding support
Obtaining results of investigations
Parenting support
Providing support during labour
Carrying out observations (e.g., BP)
Providing care for babies
Providing aspects of community care
Venepuncture

Dimond (2000) comments that the delegation of aspects of midwives' work is unavoidable if midwives are to extend their role further, especially given the current recruitment and retention difficulties seen in midwifery services. This view has also been supported by McKenna *et al.* (2006). The RCM (2005) stresses that, if MSWs must be employed in maternity services, there is a need for them to work within a framework that outlines their responsibilities and the necessary arrangements for their supervision. In addition, if some of the enjoyable aspects of midwifery care, such as providing breastfeeding support, are delegated, then midwifery practice might consist mainly of the less rewarding aspects, such as administration and supervising untrained staff, thus reducing job satisfaction and exacerbating recruitment and retention challenges.

7.5 MPs: Saviours or saboteurs?

It emerged from the data that the development of MP roles also had implications for the obstetricians. The introduction of MPs ensured that the obstetricians were protected from the negative impact of the Working Time Directive (NHSE, 2003) and sub-specialisation, which is increasing in obstetrics. However, even though the individual MPs were well accepted in the maternity unit, the overall impact of the work of MPs was initially perceived as being somewhat negative.

7.5.1 Medical staffing requirements

Obstetricians in this study initially had some concerns over the introduction of MPs. These concerns were lessening, but the research participants still felt that an increase in MPs could result in fewer obstetricians being needed in the future. Recent healthcare policies are likely to have an impact on the number of obstetricians needed in the future and this might result in the further development of the MP role. With the development of MPs, the boundaries between doctors and midwives are being altered. MacDonald (2004) estimates that if the recommendations of the Working Time Directive (NHSE, 2003) are to be complied with, the UK will need 12,000 more doctors. As this has not been achievable, consideration has had to be given to allowing other health care professionals to contribute to care provision in new ways.

However, obstetricians have recommended that further expansion of MPs' posts should not be encouraged, ostensibly in view of the concomitant implications for midwife recruitment and retention (RCOG, 2005).

> There is already a considerable shortage of midwives and this must be addressed before there can be any consideration of an extended role. Sustaining and developing the core midwifery role should always take priority over assuming new areas of responsibility.
> (RCOG, 2005:30)

This may suggest concern on the part of obstetricians about midwifery staffing levels, but it is more likely to indicate that these newer clinical roles are beginning to pose a threat to obstetricians.

It is likely that obstetricians will continue to specialise in different aspects of obstetrics and that the general obstetrician will no longer exist. *The Future Role of the Consultant* (RCOG, 2005) describes how consultants will work as generalists, specialists or sub-specialists, but the way of achieving this was seen as being by means of an expansion of consultant posts. The report also recommends that women experiencing uncomplicated pregnancies should continue to have the choice of having their care provided by a midwife or an obstetrician. Although systems have emerged in which obstetricians are given every encouragement to protect their jobs, the financial cost of such an increase in consultant posts may be prohibitive. In addition, policy documents such as *Modernising Medical Careers* (DoH, 2003b) may also provide opportunities for MPs to become generalist providers of maternity care, as it recommends that patients should not be treated by doctors in training, thus restricting the work of junior and middle grade doctors.

7.5.2 Impact on doctors' training and workload

The issue of training junior doctors was of particular concern to a number of obstetricians in the current study. These participants felt that, if junior doctors did not work at night, they would not be adequately prepared to work as middle grades. The middle grades, when working night shifts, are the most experienced obstetricians resident in the hospital. However, midwives and senior obstetricians in the study

expressed the contrary view that the previous system did not provide appropriate clinical experience for junior doctors. They argued that current middle-grade obstetricians do not appear to have benefited from the old system of clinical training (i.e., they do not appear to have received sufficient preparation for a senior post). The senior obstetricians felt that this was due to a number of factors, such as the reduction in the length and changes to the pattern of clinical training. Regardless of such concerns about the effect of MPs on the training of junior doctors, the previous system, where junior doctors worked long hours was unsafe and unacceptable.

It has been argued that the reduction of junior doctors' working hours, which resulted in changes to the ways in which they worked, has not met its aim of improving working conditions for junior doctors and may have negative implications for patient care (MacDonald, 2004, Akerman, 2005, Ahmed-Little, 2007). However, a study by Cass *et al.* (2003) found that the introduction of new nursing roles was effective in reducing junior doctors' hours, while having no adverse effects on patient care or staff work satisfaction. An additional factor, which may have resulted in junior doctors wanting to continue working night-duty may be the enhanced salary they receive when working such unsocial hours. Notwithstanding this, perhaps the concerns of junior doctors indicate a need for MPs and junior doctors to combine their rotas and cover both day and night shifts. This might benefit MPs, as they work mainly night shifts, and there is evidence that long stretches of night duty can have an adverse effect on performance and health (Knauth, 1995 and Knauth, 1996).

One of the perceived disadvantages of MP posts emerged as the potential of such workers to increase the workload of middle-grade doctors. MPs are unable to prescribe medicines and they are not trained to manage the care of patients who present with medical or surgical symptoms. As a result, they may have to refer more frequently to middle-grade doctors than would junior doctors who have the necessary experience and knowledge and who are able to prescribe medication and to refer. This limitation arising from the inability to refer has been identified in other studies where midwives have extended their practice. Lumsden (2005), in a study to investigate how midwives perceive the examination of the newborn as an additional aspect of their midwifery practice, found that these midwives could not refer directly to a senior paediatrician and were unable to order investigations themselves. Ball (2005), in a

study into advanced and specialist nursing roles, also found that systems within the NHS had not been altered in order to maximise the potential of these roles.

It appears that middle-grade medical doctors have not become accustomed to working a shift system, an unsurprising finding given the newness of shifts for doctors. Attitudes to being called at night might change as the MPs become more experienced or new policies regarding prescribing emerge. On the other hand, the current study found that some aspects of the MPs' role result in a reduction of middle-grade doctors' workload. This is mainly because MPs are unlikely to call a middle-grade doctor inappropriately when dealing with problems arising with a woman in labour. Initial concerns that the MP role would increase the workload of middle-grade obstetricians appear to be unfounded, many midwives and obstetricians felt that MPs did at least the same amount of work as junior doctors. Furthermore, respondents felt that the MP had the potential to be of greater assistance to middle-grade doctors in the future. It seems that the middle grades' workload has been altered rather than increased by the introduction of MPs.

> You are not getting called so much for minor things such as, episiotomy suturing, whether or not a patient needs to have syntocinon, so the only thing you get called to do is prescribe... you are not getting called to the ward to see a trace unless it is a suspicious CTG, and you would have to go to see that anyway. So the answer is no, it doesn't increase the workload, because if the MP is well trained and experienced then the workload should be reduced. (Obstetrician 3)

The reluctance to accept MPs may stem not only from the anxiety that they will increase the workload of middle grades, but also as a result of apprehension that they might possibly take the positions of general obstetricians. If MPs were able to extend their role successfully to take on the work of middle grades, they might expect to be able to move up through the medical hierarchy. This type of apprehension has been identified in other studies concerning nurses developing their roles. A study by Allen (2000) into the ways in which senior medical staff negotiated changes to the nurse-doctor boundary found that they were happy about technical tasks being delegated, but they had reservations about the delegation of activities they regarded as central to their role, such as making a diagnosis. Senior doctors were keen to recast nurses as subordinate workers who undertook basic technical tasks previously the domain of

doctors. Such ambivalence about the blurring of professional boundaries between nurses and doctors was also noted by Barton (2006b) who undertook an ethnographic study to explore the experience of medical mentors who provide clinical mentoring for NPs undertaking a BSc degree course. This study found that doctors' experience of mentoring NPs was generally positive. However, it was also noted that this role resulted in conflicting views about supporting a role, which challenged medical authority and produced a re-negotiation of professional boundaries.

MP roles may have potential implications for all groups who provide maternity care. The midwives were concerned that if such developments to the midwives' role were encouraged, then all midwives may be expected to further extend their role, which they were not comfortable with. The obstetricians were concerned that MP posts might affect their training, alter their workload and result in fewer obstetricians being required. In addition, as midwives take on aspects of the obstetric role, there is likely to be a further expansion to the MSW role, to ensure the more basic aspects of care are provided in a cost effective way.

In this study there was some ambivalence noted amongst the midwives and obstetricians surrounding the MP role. Both groups were welcoming and accepting of the three MPs who worked in the unit, but there was some concern regarding the implications these new roles might have on the other groups who provide maternity care. Healthcare policy initiatives, such as *Midwifery: Delivering Our Future* (DoH, 1998), are supportive of developing roles in this way. However, as a result of the concerns of midwives and obstetricians there may be barriers to the scope of the MP role extending further.

7.6 MPs: Confident progressives

MPs can be described as confident progressives who challenge the stereotypical roles of midwife and obstetrician. MPs resist the temptation to retreat to a safe position, which avoids taking responsibility and which restricts autonomy and job satisfaction. This section discusses how MPs have developed a new and distinct role, which combines positive aspects of midwives' and obstetricians' practice. It considers the

features of MPs and how they are able to bridge the gap between midwives and obstetricians. Finally, the freedoms and constraints of MP roles are considered.

7.6.1 Features of the MP role

The recommendations of health policy documents in the UK such as, *Making a Difference* (DoH, 1999) and *Realising the Potential* (NAW, 1999) call for traditional health care boundaries to be altered in order to meet changing health care needs requiring collaboration and partnership working between doctors and midwives. There are a number of studies of midwives extending their existing role to undertake specific skills, such as neonatal examinations and ventouse deliveries (Alexander *et al.* 2002, Mitchell, 2002a and 2002b, Townsend *et al.*, 2004). However, the MP role, where midwives have taken on a new role to undertake aspects of the obstetric and gynaecology role, has not previously been examined. There was no planning for this initiative and NHS Trusts developed job descriptions and person specifications without guidance or national agreement regarding the scope or competencies for this new position. The current study has shown that this lack of definition inadvertently resulted in the creation of a distinct health care role, which encompasses positive aspects of both the midwives' and obstetricians' work (see Figure Three). There were originally three MPs in Wales in the late 1990s, and there are now approximately 27. The Welsh Assembly Government funded the MP role in Wales from New Deal monies. This is why comparisons between the financial costs of MPs as opposed to SHOs have not been considered in this study. However, other studies have found that NPs are not more cost effective than employing junior doctors, though there may be long term benefits associated with this type of care provision (Venning *et al.*, 2000, Sakr *et al.*, 2003).

The practice boundaries between different healthcare professions have never been constant and healthcare policy in the UK currently actively encourages workforce flexibility, allowing other health care groups to participate in traditional medical roles. Healthcare workers can change their areas of practice by impinging on other's areas of responsibility or by consensual delegation, where unwanted tasks are discarded to subordinate groups (Nancarrow and Borthwick, 2005). Such redesigned roles are

described using a number of terms, but generally they fall into the following categories: new roles, which create a completely new type of health care worker, extended roles, where additional tasks or duties are required, and changed roles, where the volume of existing activity is altered. There are a number of reasons for developing new roles, these include improving patient safety and standards of care, improving career opportunities for staff, reducing gaps in service provision and avoiding duplication of care (NLIAH, 2007).

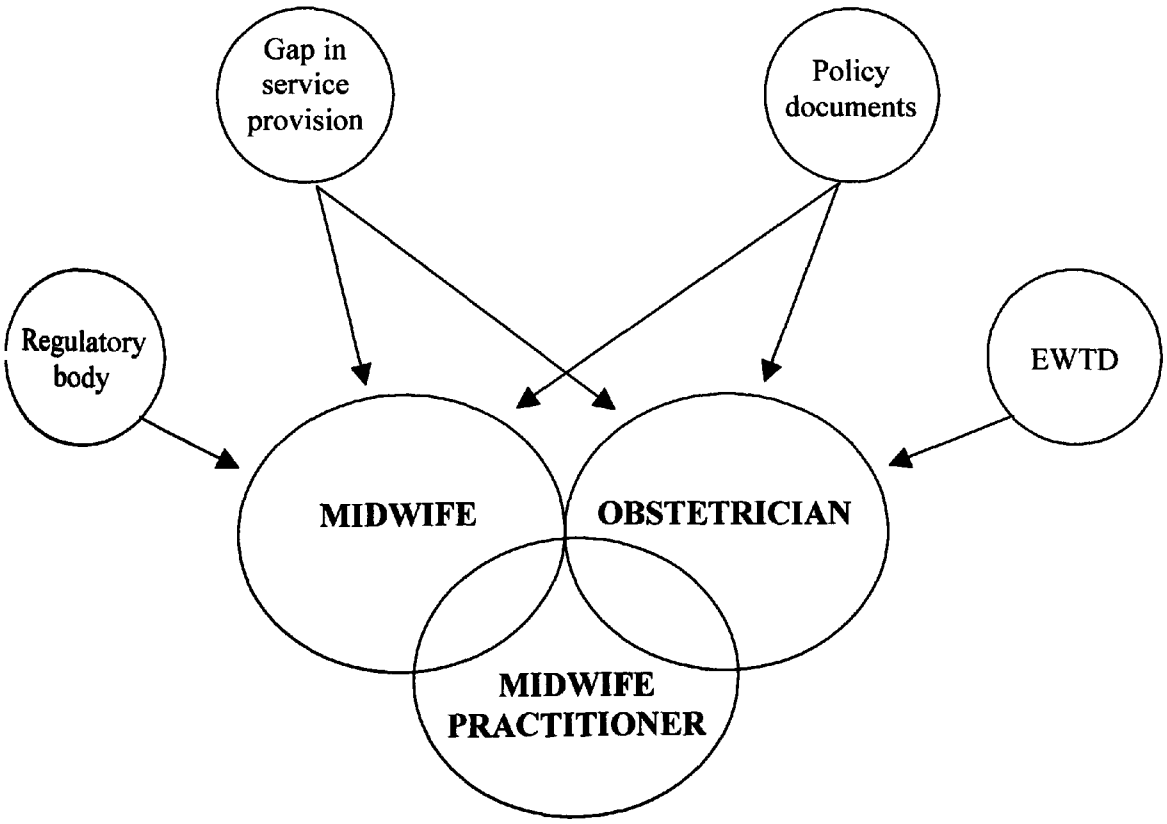
MP posts reflect aspects of all three types of redesigned roles and were developed to fill the gap in service provision resulting from reductions in junior doctors' working hours. When new roles are developed, a structured approach should be employed that considers the need of the service along with those of stakeholders, and any necessary changes are made prior to introducing the redesigned role (NLIAH, 2007). However, in the NHS, new developments quite often owe more to expediency than careful forethought. Such changes are generally initiated to meet existing pressures and within very tight timescales – often with little preparation, as was the case with the introduction of MPs. The pressure to find solutions to issues quickly, resulting in a lack of planning and consideration of the impact of change, seems to be a feature of the NHS, where one change is quickly replaced by another. For example, in Wales there was a major change in the structure of the NHS in 2008, which is to be followed by a further radical change in 2009.

Lavender and Edwards (2007) argue that new midwifery roles are developed to fill the gaps in service provision caused by other professional groups – namely, obstetricians – and argue that by extending their practice in this way, midwives are devaluing midwifery. They emphasise the risk that, in extending their practice to cover the work of junior doctors, midwives might begin to espouse a medical model of care. This argument supports the views of the tentative traditionalists, who say that MPs will concentrate on the provision of physical care to the exclusion of the provision of holistic, woman-centred care. However, in the current study, it was apparent that the MPs were committed to providing safe, holistic care, and thus to taking into consideration the emotional and social needs of the woman and her family while providing appropriate health education. MPs try to develop a rapport quickly with both women and their partners by speaking to them in a way they can understand

and by encouraging them to participate in discussions: 'I think midwife practitioners bridge the gap between midwives and obstetricians as they do a bit of both jobs. I think they will bring midwives and obstetricians together' (Obstetrician 2).

MPs appear to be competent to substitute for junior doctors and they are able to provide safe care – as demonstrated by other studies into the extended role of the midwife (Lee *et al.*, 2001, Townsend *et al.*, 2004). However, midwives, demonstrating the characteristics of tentative traditionalists, feel that MPs should be aware of their limitations, in order to ensure that they practise safely. Paradoxically, the midwives were happy to refer to the MPs, whom they felt were more confident and less nervous than the junior doctors. Warwick (2000) discussed how it is a waste of resources for midwives to defer to junior medical staff who may have less knowledge and experience than the midwife. MPs saw the process of childbirth as a normal process, whereas junior doctors tended to hold the view that childbirth was a time when things could go wrong and that they should be cautious in their management of care provision.

Figure Three: Factors leading to the creation of the MP role in Wales



A study undertaken by Reime *et al.* (2004) also notes these different approaches to care provision. Using postal questionnaires completed by midwives (n=50), obstetricians (n=97) and family physicians (n=34), they found that midwives and obstetricians had markedly different views regarding the use of technology and intervention, demonstrating their different perceptions and approaches to providing care for women during childbirth. Midwives' commitment to maintaining normality was also demonstrated in a study by Alexander *et al.* (2002), which examines the role of MVP. MPs, in addition to providing holistic care, had developed the confidence and analytical skills when making decisions that are normally demonstrated by medical staff. They did not seem to worry about taking responsibility and making decisions in the same way other midwives did. As a result of this MPs were able to bring enhanced value to the role previously undertaken by junior doctors.

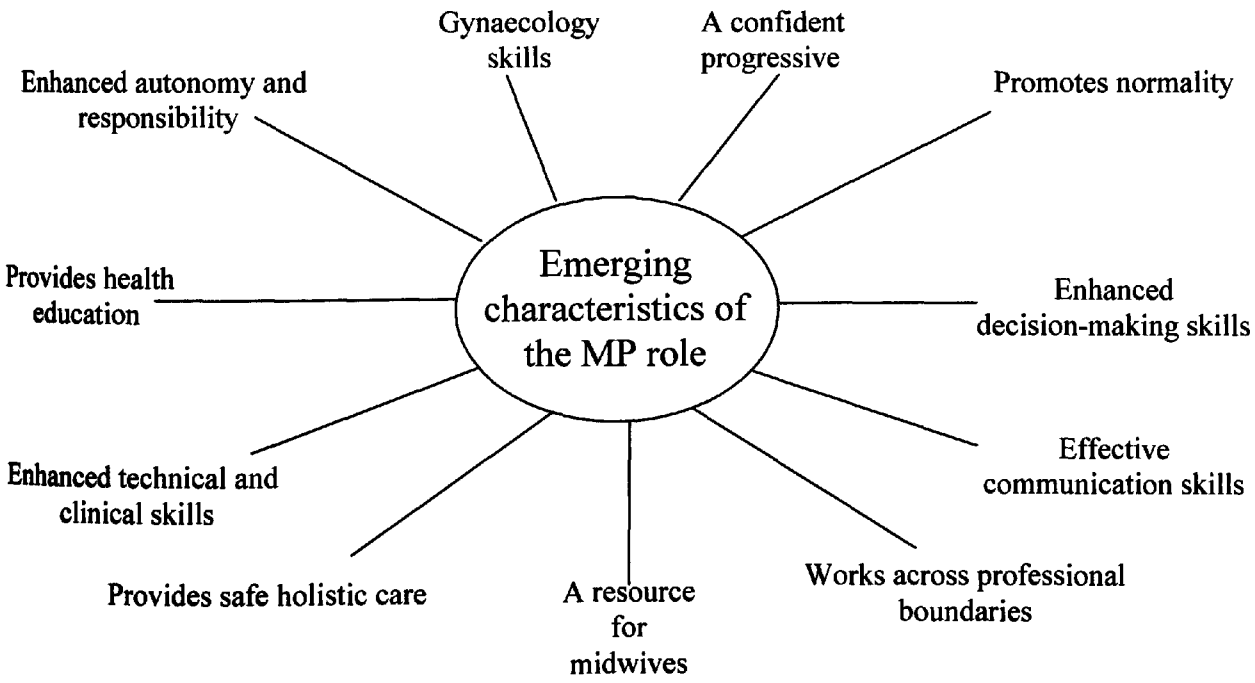
Wicks (1998) argues that it should be possible to combine these different types of care and the current study demonstrates that MPs have achieved this. They provide the essential aspects of the midwives' role, while developing the skills normally demonstrated by doctors and, at the same time, encouraging midwives to further extend their practice (see Figure Four). As the number of MP posts increase, there is a need to ensure that this blending of the positive aspects of the midwifery and obstetric roles continues. Wicks (1998) states that nurses provide empathic, holistic bedside care for patients, which compensates for the lack of empathic care provided by doctors. This allows doctors to concentrate on the diagnosis and treatment of illnesses, in line with their mechanistic and reductionist model, in the knowledge that nurses are addressing other aspects of care, such as communication. The current study also found that doctors tended to rely on midwives to deal with the emotional and social aspects of care, leaving them to deal with purely physical conditions.

MPs practice in accordance with the midwifery model of care and avoid using the medical model of care, which has been shown to increase medical interventions during the childbirth process. Kennedy (1981) argues that the medical profession cultivates a preoccupation with identifying diseases, rather than the maintenance and promotion of normality and health. Charles (2002) comments that MVPs also use their midwifery philosophy of care to keep the process of birth as normal as possible, however, it is currently too early to judge whether MPs have reduced the

medicalisation of childbirth, and this issue is outside the scope of the current study. The reasons for the increase in the medicalisation of childbirth, during the latter part of the twentieth century, are multifaceted and this trend will be difficult to reverse (Cahill, 2001, Wolf, 2001, O'Connor, 2001a, 2001b).

MPs also successfully substitute for junior doctors in the gynaecology department – for example, dealing with clinical assessments, planning care and assisting middle grades during surgery. One of the differences between midwives' and MPs' work was the inclusion of gynaecology in the MPs' role and their increased confidence in dealing with clinical issues without automatically referring to medical staff. The current study found that there was a mixed reaction regarding the issue of MPs providing care for gynaecology patients. Some felt that with additional support, it would be acceptable, however, others questioned whether midwives could safely extend their role to work in an area so distinct from midwifery. However, in areas such as A&E departments, NPs have been successfully providing care previously undertaken only by doctors for some time (Dolan *et al.*, 1997, Sakr *et al.*, 2003).

Figure Four: Model of the emerging characteristics of the MP role



7.6.2 A successful development

In the current study there was limited understanding and a diversity of opinion regarding the work of the MP. The tentative traditionalists felt that these posts received undue prestige, and they expressed the view that these roles resulted in the exploitation of midwives. The issue of whether MPs were still practising as midwives was discussed, and the view was expressed that these posts would allow midwives to use their expertise to normalise childbirth. It was noted that there had been some hostility by the midwives regarding the MP role, and that there was still some conflict between the two groups, which may reflect a degree of uncertainty about any further development of the midwives' role. Marshall (2005) suggests that although midwives have extended their practice to undertake such procedures as ventouse deliveries and ultrasound scans, this increased autonomy is illusory and may result in midwives becoming 'low-class' medics. McKenna *et al.* (2006) found that it was important for new roles to still be identifiable as midwifery jobs, rather than just being responsible for providing aspects of medical care. The diversity of ways in which midwives now practise may cause confusion about the image of midwives and therefore the way they are perceived by the public.

All of the participants in phase three of the study felt that the MPs were able to provide safe and effective care, and clients and their families accepted without question being seen by MPs rather than doctors. From the clients' perspective, it does not seem to matter which health care professional provides their care, as long as they feel safe and confident in that person. This finding might also suggest that they did not feel sufficiently empowered to challenge the MPs and ask to be seen by a doctor. The acceptance of MPs was confirmed by other studies into the extended role of the midwife (Mitchell, 2002a and 2002b, Townsend *et al.*, 2004). Although the MPs were accepted by both their colleagues and their clients, they remained on the periphery of a number of different teams. Despite this, they still felt that they wanted to integrate into the midwifery team and made a conscious effort to do so. It is an essential component of MP posts to work across speciality boundaries. However, all of the MPs were vulnerable in that they did not fully belong to any professional group. The need for support for new nursing and midwifery roles was also identified by Ball

(2005) and McKenna *et al.* (2006). This vulnerability may be a possible weakness, but may lead to the development of a cohesive relationship among the MPs themselves.

> I think you feel a bit a part of all teams really, midwives, doctors, managers and your own team [MPs]. But you are not really a member of any of the three and maybe that's the difficulty. (Lyn)

The MP role has changed from the traditional midwifery role in a number of ways, which can be related to the different roles described in *Role Redesign in the NHS in Wales* (NLIAH, 2007) (see section 7.6.1). The number of areas where MPs worked, as reported in this study, has expanded to include accident and emergency departments, outpatient departments, theatres and the gynaecology ward. In addition, MPs have extended the breadth and depth of their knowledge in order to practise as midwives, obstetricians and gynaecologists (see Appendix 3). The MP role may also result in the boundaries between midwives and obstetricians blurring, encouraging greater harmony between two professions that have traditionally been in competition with each other over the provision of maternity services (Stevens, 2002).

MPs generally have a good working relationship with obstetricians, which may result from them sharing many of the same responsibilities and work-related issues. However, it was noticed that MPs worked hard to develop and maintain the relationship. The obstetricians were keen to involve MPs in their meetings and teaching sessions and share aspects of their work. There was, however, an awareness of the need for MPs to set boundaries, and it was perceived that there was still a need to be cautious and ensure that MPs were not being exploited to meet the needs of the obstetricians: 'I think, like I said, we can be spread too thinly because we can do two jobs, um, I think as far as the doctors are concerned, we need to make sure we keep to our agenda' (Sara). This concern was demonstrated by Harvey (1995), who found that midwives who extended their role to undertake aspects of obstetric care were often pressured by the demands of service delivery and the unwillingness of medical staff to be there. Considering the adverse effect of previous healthcare policy initiatives for midwives, it is understandable that they should be cautious about being exploited. In spite of these concerns, the MP role was viewed as being a bridge between the midwives and obstetricians, bringing enhanced value to both.

7.6.3 Freedom and constraints

MPs appear to provide safe and effective care and are supportive of each other in developing their knowledge and expertise further. However, there were some concerns about the lack of nationally agreed criteria for evaluating competencies, a lack of knowledge regarding other specialities, limited prescribing rights and a lack of agreement regarding training and updating. If midwives are to extend their role successfully, there is a need for both adequate funding and for existing systems and infrastructures to be changed and developed to support them. Other studies have also found that the organisational infrastructures have not been developed in line with new roles and ways of working, and that the need for appropriate clinical supervision to avoid isolation has not been considered (Ball, 2005, McKenna *et al.*, 2006).

Dowling *et al.*, (1996) found that if the scope of new nursing roles was fully maximised, then patients and NHS Trusts would benefit from improvements in care provision. To make this achievable, issues such as education, role specification, and recognition of the status of the nurse practitioner should be addressed. Though new roles have the potential to result in confusion over accountability, risks can be reduced through close partnerships between nurses/midwives and doctors in the planning, training and management arrangements for these roles. NLIAH (2007) has developed a comprehensive system that can be followed when considering changes to existing roles. It is hoped that this will assist in ensuring that future developments are systematically planned and any alterations are made prior to the introduction of the change. It became apparent during the current study that most participants believed that the MP role was developed without consideration of the need to agree on competencies or amend systems to ensure its success.

The current study has also found that the lack of preparation for the development of the MP role in Wales has resulted in there being few constraints regarding the care they can provide. While there is a need to address the issue of responsibilities and competencies, MPs have been allowed to work in an unrestricted way, unlike in other areas where midwives have extended their role (Townsend *et al.*, 2004). There is controversy over the necessary educational preparation for nurse practitioners,

although courses are available for them in a number of universities (Carlisle, 2004), but there are no specific courses currently available for MPs. If these new roles are to be successful, there is a need for postgraduate courses that combine aspects of medical and midwifery training, but to date there are no plans for such courses.

Wicks (1998) suggests that the best aspects of the nursing and medical professions could be enhanced by combining the initial stages of training, where both medical and nursing students would undergo nurse training, then after a period of working as nurses, they could decide if they wanted to develop their careers either in nursing or medicine. It is highly unlikely that prospective candidates for the medical profession would find providing the basics of caring for patients an attractive option, when more lucrative and prestigious career options are available to them. In fact, it could be argued that midwives, nurses and doctors have completely different personality traits, mindsets and needs. It is possible that a combined training programme for medical students and student midwives might improve the communication skills of medical staff and the responsibility-taking and decision-making skills of midwives, as recommended by Dyas and Burr (2003).

Although Wicks (1998) asserts that it should be possible to combine holistic care with good diagnosis and treatment, she points out that as nursing has become more professionalised and nurses have extended their role, there has been an increase in the number of health care assistants who provide the more basic aspects of nursing care. This raises the question of whether the combination of these two aspects of care can be sustained. Specialisation is a process that refines nursing and midwifery care and which requires a level of knowledge exceeding that of a midwife or nurse who has completed basic registered training. It has been argued that specialisation improves client care, as specialist midwives and nurses have a narrow but focused clinical base. These specialists have reported more job satisfaction stemming from increased status and a mastery of the knowledge base of their particular speciality (Scott, 1998). In the current study, the MPs felt that one of the reasons for midwives' dissatisfaction with their role was that they had to be experts in all areas of maternity care, the MPs held the view that it would be better for midwives if they worked in one area where they could develop their expertise and confidence.

Specialisation and extended roles have attracted doctors, midwives and nurses away from the core aspects of their role and into areas that are regarded as being more prestigious and which receive enhanced financial support (Kennedy, 1981, Scott, 1998). This can result in those midwives who do not work in specialised and extended ways feeling undervalued, as basic aspects of their role, functions that they value and perceive as important, are delegated to MSWs. Despite arguments to the contrary, it is likely that the number of MP posts will increase, as has happened with non-physician clinicians in the United States (McKinlay and Marceau, 2002). MPs can undertake a range of different functions and work in a more generalist capacity, which should assist in the development of more cost-effective and efficient maternity services. MPs are too new to be able to fully appreciate the possibilities that working as an MP could offer to confident progressive midwives, who are prepared to take on the necessary responsibility. The very newness of the MP workforce makes it impossible to estimate the potential benefits to women and midwives.

> Midwifery care is often undervalued and, within the scientific language of obstetrics, the gentle art of midwifery is rarely acknowledged. However, if midwives can apply their unique perspective to abnormal obstetric care they will demonstrate the possibility of combining their midwifery skills with more advanced techniques. (Hartley, 1997:775)

However, the use of language by the midwives in this study (see section 7.3), may possibly demonstrate a deep-seated, unspoken desire to comply with the medicalised approach to providing maternity care. This may allow them to avoid responsibility and work in ways, which are perceived as being safe. Although this may have perceived advantages for maternity care providers it does not necessarily meet women's needs. It also gives an indication of how the culture in maternity services can undermine health care policy recommendations, when these do not fit with the overriding beliefs of those who work in maternity care. An example of this was the recommendations of the *Changing Childbirth Report* (DoH, 1993), for improved choice, control and continuity for women. Although there has been some progress towards these goals, the medicalisation of childbirth has continued unchecked. This is in contrast to the recommendation of *The Peel Committee* (DHSS, 1970) for 100% of births to take place in hospital, which was very successful. This may reflect the weak position of women and midwives in particular within society; however, it can also be

seen as an initiative, which maternity care providers were happy to comply with. Though this can be perceived as being a very simplistic interpretation, it may well be pertinent for the future development of the MP role.

7.7 Strengths and weaknesses of the study

One of the major strengths of the current study was that it was undertaken while the role of MP was still developing, so recommended changes to systems and adaptations to the role can be made early on in the process. Undertaking this study provided the researcher with the opportunity to attend an All-Wales Midwife Practitioner Group in 2005, to discuss the core aspects of the MPs' role and the competencies and training needed for these practitioners to be successful. During the meeting, it was apparent that though they had different titles and job descriptions (see Appendix 14), the MPs all shared the same concerns and uncertainties about their role. The researcher is able to continue the work with this group and help them decide on the core aspects of their work and the educational support they need. In addition, the researcher has been invited to join an all-Wales stakeholder group for a pilot study into the rapidly developing role of MSW, which has been funded by the RCM.

By undertaking a focused ethnographic study, this thesis has produced information that has made explicit that which is implicit about the role of MP and its effects on both care provision and other related health care staff. The preliminary epistemological indicators arising from this study could be used to guide further, larger scale, research. The results of this further research might be used by policy-makers and healthcare managers to establish effective new midwifery roles that might help with delivering the targets of the NHS modernisation agenda. This thesis can also provide research participant midwives with insights into the ways in which their profession has been shaped and constrained, and can provide indicators as to how midwives can challenge the limitations to the scope of their practice. This could allow them to extend their role in ways that meet the needs of midwives and childbearing women, rather than merely meeting the requirements of ever changing health care policies.

The findings of the current study can also help make the obstetricians more aware of the risks inherent in using other healthcare groups to fill gaps in service provision, especially gaps occurring in response to changes in the ways in which obstetricians work. Moreover, it may encourage obstetricians to deal with issues within their profession without recourse to the potential exploitation of other health care workers. In addition, this thesis has highlighted the need for midwives to become actively involved in the future development and monitoring of the MSW role and the planning and preparation for further developments to the midwives' role. This involvement can preclude the exploitation of MSWs and ensure that future maternity services safely meet health care needs. Finally, this study has also provided information regarding the type of care from maternity services that women find acceptable, and it can help identify the attitudes and approaches of health care professionals that result in a high level of satisfaction among maternity care users.

A limitation of this study was that I was a manager undertaking research in my own workplace. McEvoy (2001) explores the subject of undertaking research in familiar areas and identifies four limitations of having an insider's perspective. Firstly, it is difficult for researchers to question things that are self-evident when they are familiar with the social scene. Secondly, insiders may be unable to maintain a balanced, objective perspective about a social world of which they are members. Thirdly, researchers may not ask questions regarding well-established social mores. Finally, there may be a reluctance to ask a member of a social group about sensitive issues. As the researcher of the current study was a midwifery manager, participants may have felt inclined to give the type of responses of which they felt the researcher would approve. Though this may have influenced the way in which staff responded and the way I fitted into the study area, it did allow for a greater understanding of the situation (McEvoy, 2001). (See section 3.6).

Phases two and three of the current study were undertaken on one site, and though qualitative research is never generalisable, a study involving a number of other units and MPs may have generated different and more informative data. A qualitative study was not able to assess the effect of MPs on the medicalisation of care provision during childbirth, or the safety of the care provided by MPs compared to the care provided by junior obstetric doctors. Ethnographic studies have a role in identifying questions and

hypotheses, which can be investigated using other methodologies (Baillie, 1995, Savage, 2000). There is also a lack of evidence regarding the effect of nurse practitioners on clinical outcomes (Carlisle, 2004, Lathlean, 2007), so no lessons can be learnt from the nursing profession. These issues were outside the remit of this research study, however, they appear to be issues which need to be explored and are discussed further in the next chapter. Nonetheless, the strength of using the methodology employed in this study is that it allowed for data to be gathered by a system of triangulation using a variety of research tools, which necessitated a number of stakeholders' perspectives being brought to bear, giving equal weight to the views of clients and health care staff.

Enough time needs to be spent in the field to allow participants to accept and feel comfortable having the researcher around. The two weeks of night duty that I spent shadowing the MPs yielded long periods of useful observation. I could have spent longer, perhaps during the day, but might not have seen as much in a month as I did in eight nights. Having reflected on this period of participant observation, I find it quite satisfactory. Furthermore, as I knew the participants and the maternity unit, I was able to fit into the research setting quickly, however, it is accepted that this may have had an effect on the research findings.

Though only three MPs were observed during Phase two, in qualitative research, it is the depth of the relationship between the researcher and participants and the depth of the analysis that are important, rather than the number of participants. As Sandelowski and Barroso (2002) point out, qualitative researchers often use an apologetic stance when discussing the small sample size in their studies, but this gives the wrong impression and betrays a preoccupation with the idea of generalisability, which is not applicable to the qualitative research undertaken here. In addition to participant observation with MPs, data regarding this role was collected from others in the research setting, along with 48 midwives from a variety of NHS Trusts during the focus groups in Phase one and 27 health care workers and clients who were interviewed in Phase three.

7.8 Contribution to knowledge

This insightful study contributes to the current body of knowledge regarding new and extended roles in midwifery in light of health care policy changes in the NHS. Other studies have considered extended midwifery practice and new roles in nursing such as the NP role. However, this is the first study to consider the relatively new role of MP in Wales, using an ethnographic approach, which is a suitable method for studying unexplored subjects.

Extensions to the midwives' role in the past have involved extending practice while maintaining the main traditional midwifery role. However, MPs work specifically as substitutes for junior obstetric doctors. This study has demonstrated that MPs are not only able to undertake the work of junior doctors, but are also able to bring enhanced value to the role, by improving communication with clients and their families, and by providing holistic care. Unlike NPs, MPs do not order more investigations, refer more frequently to doctors or arrange more follow-up appointments than junior doctors. Unlike other extensions to the midwives' role, the practice of the MPs is not inappropriately restricted, nor do they have to demonstrate their competencies in different ways to the obstetricians. MPs appear confident in accepting the additional autonomy of their new role and are perceived as being able to undertake more work than junior doctors and of being of more support to middle grade doctors. However, unless obstetricians respond positively to health policy initiatives such as *Modernising Medical Careers* (DoH, 2003b), which recommends that only fully trained doctors should provide direct patient care, there will be no requirement for all midwives to work in this way. Indeed the resultant requirement for training and updating such skills for all midwives would be prohibitive.

There was no planning for the development of the MP role and NHS Trusts developed job descriptions and person specifications without guidance or national agreement regarding the scope or competencies for this role. The current study has shown that this inadvertently resulted in the creation of a distinct health care role. This study found that the MP role combines positive aspects of both the midwifery and obstetric roles, thus enabling them to provide a midwifery model of care whilst confidently utilising technical and analytical skills. Consequently, this study indicates that when

new roles are developed the controls regarding scope of practice and competencies required should not be too restrictive. This study also found that current systems need to be adapted such as, making referrals to other specialities and prescribing, if these new roles are going to reach their full potential. This study noted that there was a lack of nationally agreed criteria for evaluating MPs competencies and a lack of agreement regarding the necessary training and updating for MPs.

In this study the MP role was viewed as being a bridge between the midwives and obstetricians, bringing enhanced value to both. This study found that the MP role is distinct and complex, requiring diverse decision-making skills, along with the ability to undertake holistic assessments and communicate effectively with clients, their families and multidisciplinary healthcare groups. This study recognised that it is an essential component of the MP role to work across speciality boundaries. However, all of the MPs were vulnerable in that they did not fully belong to any professional group. Therefore, the need for support for this new role was identified. The study found that MPs were accepted by clients, midwives and obstetricians. The MP role was also found to increase clients' satisfaction and knowledge about their health care.

The midwives and obstetricians in this study felt that the MP role benefited client care, staff development and reduced the number of calls the middle grade doctors received during the night. The MPs generally had a good working relationship with the obstetricians. However, even though the obstetricians accepted the need to develop the role of MP, they were somewhat ambivalent about the effect further extensions to the MP role might have upon them. This study found that there was an awareness of the need for MPs to set boundaries. It was perceived that there was still a need to be cautious and ensure that MPs were not being exploited to meet the needs of the obstetricians. This study found that MPs need to develop their assertiveness skills, to avoid being seen as 'just another midwife' who can help out during busy times, as such a perception could result in them being used inappropriately and, moreover, affect the success of their role. This could also cause confusion and conflict over roles and responsibilities.

This study established that the midwives who participated in the research did not perceive that they were negatively affected by this new role. The study found that the

midwives generally did not want to extend their role in this way and were content to provide care during normal childbirth and refer to obstetricians when any problems occurred. It also explored the reasons why midwives accept the restrictions to their practice and why they are unable or reluctant to alter their position and accept further autonomy.

The findings of the current study establish an evidence base for further developments in midwifery practice, by providing insights regarding this new role. This study should be followed up by larger studies, the results of which might be generalisable. This study has also addressed the gap in current knowledge concerning policy and practice by exploring this complex clinical and organisational development, to make explicit what is implicit about the new role of MP and its impact on midwives and obstetricians in the research setting. The following chapter outlines the conclusions and recommendations of this study, illustrating further how this thesis contributes to the existing knowledge regarding this subject.

CHAPTER EIGHT – CONCLUSIONS AND RECOMMENDATIONS

We need to disrupt prevailing notions of what is inevitable, what is natural, and what is impossible. We need, therefore, to invent and publish images of what is not now, and what could be. (Fine and Gordon, 1991:24)

8.1 Conclusions

The findings of the current study contribute to the body of knowledge concerning policy and practice in relation to the extended midwifery role of MP. As there has been no previous published research into this new role, it was felt that the qualitative paradigm was most appropriate as was the ethnographic approach. The method, approach and tools best suited the collection of appropriate data to answer the aim of the study, which was - To explore the role of the MP and its impact on midwives and obstetricians in a maternity unit in Wales. This study was conducted in three Phases. Phase one was undertaken in order to place the findings of the main part of the study in context. This was deemed necessary as previous research considered midwifery practice in England rather than Wales. It also provided information on midwifery at that particular time. In addition, it provided a basic understanding of how midwives perceive the role of MP. Phase two was then undertaken in order to see and hear how MPs practice and how this role impacted on midwives and obstetricians in the research setting. In Phase three I explored these issues in more detail by asking clients, midwives and obstetricians about this subject matter and by exploring further what I had seen and heard during Phases one and two. This allowed a clearer picture to be developed about this role and its impact on the midwives and obstetricians working in the unit.

This study concludes that the establishment of MP posts has created a distinct and unique role that utilises the specific skills of both midwives and obstetricians, to provide effective and acceptable care for clients. It is apparent that the role of MP has been interpreted differently in maternity units throughout Wales and it might be too early to understand fully how these posts will develop in the future. However, they

have the potential to blur the boundaries between midwives and obstetricians, allowing MPs to work within the maternity services in a generalist capacity. Consequently, the findings of this study raise issues regarding the future development of the midwives' role, and for those who provide maternity services in Wales. This chapter draws together the key issues raised in the study, in order to provide conclusions and recommendations about the MP role and its impact upon midwives and obstetricians in the unit where the research was undertaken.

8.1.1 The consequence of MPs for midwives

This study concludes that the midwives had a clear understanding of the essential functions of their role and felt that women need to see that their midwife can provide safe care and appears confident in her manner and actions. The midwives in this study felt that it was part of their role to take control over women's decisions and choices in labour. This reflects the medical model of care rather than the midwifery model of care, the latter of which stresses the need for women and their families to be involved in decision-making and choices regarding the care they receive.

This study found that on occasion, an inadequate number of midwives available to provide care results in the need to delegate the work of midwives to MSWs, which indicates a need to clarify MSWs' responsibilities and the necessary arrangements for their supervision. As more midwives move into specialised roles such as MP posts the delegation of midwives' work is likely to continue.

The midwives felt that they were seen by doctors and nurses as being elitist and sometimes difficult to work with and they were not unduly concerned about their image. However, this approach may be problematic, as current UK health policy documents recommend multi-disciplinary working, if midwives are to secure and enhance their position as maternity care providers they need to work collaboratively with others.

Although health policy documents in the UK are supportive of autonomous midwifery practice, the pressure on midwives to conform, as identified in this study, has resulted

in the majority of the midwives working as tentative traditionalists. These midwives tend to retreat into the safety of deferring to obstetricians and 'glorify their oppression' by portraying the perceived limitation of their role as a positive characteristic. Only a minority of midwives in this study wanted to take on the responsibility of the MP role. These midwives can be described as 'confident progressives' who are prepared to embrace change and the extended role of the midwife. The approach of the tentative traditionalists place midwives in a weakened position in the provision of maternity services and puts their future at risk, at a time when the recommendations of healthcare policy documents are encouraging the development and extension of health care roles.

The midwives in this study were unsure about the development of MP posts, and their main anxiety was that MPs might be moving away from the fundamental characteristics of the midwives' role. This study illustrates the ambiguities felt by midwives about MPs. A number of midwives felt that MPs were being exploited for the benefit of obstetricians and questioned whether midwives should be developing their practice to cover a shortfall in medical staffing at a time when there were already midwifery recruitment and retention issues. Conversely, some midwives expressed the view that the establishment of MP posts had benefits in terms of recruiting and retaining midwives, as this development could improve their image. The view was also expressed that these posts could allow midwives to use their expertise to normalise childbirth. However, it is currently too early to judge whether MPs have affected the medicalisation of childbirth, and this issue is outside the scope of this study.

8.1.2 The impact of the MP role for the obstetricians

This study concludes that there was ambiguity regarding the impact of MPs for the obstetricians. Generally, the obstetricians were supportive of the MPs and welcomed them into their team. However, concerns were identified regarding the impact of MPs upon the training of junior doctors, though there were conflicting views about this issue. Although there was initial concern that these posts would increase the workload of the middle grade obstetricians, it seems that this has in fact been altered rather than

increased. MPs are unable to prescribe and are not trained to manage the care of clients who present with medical or surgical problems. Moreover, MPs cannot make referrals to other specialities. For all these reasons, they may have to refer more frequently to middle grades than would junior doctors. However, this study established that other aspects of the MPs' practice results in a reduction in middle-grade obstetricians' workload, as MPs were not likely to call them inappropriately when dealing with intrapartum issues.

This study also identified apprehension about the effect this new role could have, if successful, on the number of obstetricians required in the future, as MPs might be regarded as a more cost effective option. Nevertheless, a number of constraints upon the MP role restrict them from working to their full potential. Both the midwives and obstetricians felt that MPs had the potential to extend further their remit in the future, especially as they increase their knowledge and expertise and if existing systems are changed. One can conclude from this study that although the obstetricians were positive about the success of the MPs they worked with, it may well suit them to limit the work of the MPs to ensure that they are unable to pose a threat to their position within the maternity services.

8.1.3 MP: A new role to reclaim midwifery

This study concludes that MPs are confident progressives who challenge the stereotypical roles of midwife and obstetrician, they resist the temptation to retreat to a safe position where they can avoid taking responsibility and which restricts autonomy and job satisfaction. There was very little planning for this initiative and these new posts developed without guidance regarding the scope and competencies for this role. This inadvertently resulted in the creation of a distinct health care role that encompasses the positive aspects of the midwifery and obstetric roles. However, ideally when new posts are developed, a structured approach should be used that considers the needs of the service along with those of stakeholders, and ensures that any necessary changes are made prior to introducing the redesigned role.

This study has demonstrated that MPs are able to successfully provide a midwifery model of care for women at high risk of developing obstetric complications. It was apparent that the MPs were committed to providing safe holistic care, taking into consideration the emotional and social needs of the woman and her family, while providing appropriate health education. They were able to develop a rapport quickly with both women and their partners by speaking to them in a way they could understand and by encouraging them to participate in discussions. In addition, MPs have developed the confidence and analytical skills, normally demonstrated by medical staff (see Box Seven). As the number of MP posts increase, there is a need to ensure that this blending of the positive characteristics of the midwifery and medical roles continues. MPs appeared competent to provide safe care, though midwives, demonstrating the characteristics of tentative traditionalists, felt that MPs should be conscious of their limitations to ensure they practised safely.

Box Seven: Emerging characteristics of the MP role

Provides safe holistic care.
Provides health education.
Good communication skills.
Promotes normality during the childbirth process.
Good decision-making skills.
Enhanced technical/clinical skills.
Enhanced autonomy and responsibility.
Works across professional boundaries.

MPs have extended the breadth and depth of their knowledge bases and are blurring the boundaries between obstetricians and midwives, encouraging greater harmony between the two groups. MPs generally have a good working relationship with the obstetricians who have been keen to involve them in all aspects of their work. However, the MPs were aware of the need to set boundaries to ensure that they were not exploited to meet the needs of the obstetricians.

8.2 Recommendations

The weak evidence base regarding the MP role and its impact on the midwives and obstetricians provides good opportunities for research and further development in this

area. A number of specific recommendations regarding these issues have been identified throughout this thesis and are brought together in relation to policy, practice and research.

8.2 1 Recommendations for policy

Healthcare policy initiatives from WAG, along with the managers of the midwifery profession in Wales, should ensure the development of an overarching strategy to proactively plan developments to the midwives' role, rather than reacting to changes that are imposed on them. This would ensure that the implications of any further developments to the midwives' role could be considered before changes were made and ensure that the midwifery profession develops in a way that best meets the needs of both clients and midwives.

Service commissioners and providers should consider funding more MP posts in maternity services throughout Wales.

New roles should be identifiable as midwifery roles, rather than just providing aspects of the medical role, in order to ensure that the diversity of ways in which midwives now practise does not cause confusion about their image and the way midwives are perceived.

There is a need for midwifery managers in Wales, along with education providers, to establish the training needs for MPs, and for health care providers to decide whether the costs for this training should be financed by the midwifery or the medical study-leave budgets.

Consideration should be given to developing a seamless and linear education system that provides training for MSWs, midwives, MPs and obstetricians at different levels, and which allows career progression to start and stop at any level. However, it is acknowledged that such an education system would require multi-disciplinary cooperation between medical and midwifery educational establishments in Wales, which may be difficult to achieve.

The existing support networks for MPs need to be further developed by both the leaders of the midwifery profession in Wales and by MPs themselves.

The future workforce needs of both the midwifery and obstetric professions should be established, taking into consideration the extensions to the midwives' role.

8.2.2 Recommendations for practice

Midwives have much to learn from MPs who have developed and extended their role, in order to provide women with a midwifery model of care, regardless of their risk status. If midwives are to strengthen their position in the provision of maternity care consideration should be given to more midwives extending their role in this way.

A database should be created by service managers in Wales, of the various ways in which midwives have extended their role, so that they may collate existing knowledge and provide examples of good practice.

Prescribing rights for MPs should be agreed on, along with a list of the drugs that they will need to prescribe. In addition, appropriate training courses should be developed, to ensure they are competent in prescribing these medications.

Consideration should be given by policy-makers to how much knowledge MPs should be expected to have regarding the management of conditions that are outside obstetric and gynaecology specialities. Additionally, appropriate training should be made available to MPs, in order to ensure they have the opportunity to acquire the necessary knowledge enabling them to refer confidently.

If MPs are to avoid being restricted to junior posts within the obstetric hierarchy, there is a need to further develop their skills, including the undertaking of operative deliveries, such as forceps delivery.

8.2.3 Recommendations for research

This ethnographic study has highlighted a number of areas for further research:

The effectiveness and safety of MPs compared to junior obstetric doctors should be established, to look at outcomes of care provision for mothers and babies.

The effect of MPs on the type and level of medical interventions carried out during childbirth should be examined.

Maternity service managers in Wales and the RCM should work together to research which aspects of the midwives' role should be delegated to MSWs.

A large scale study should be undertaken into how satisfied users are with MPs.

8.3 Concluding remarks

In the past, there has been an acceptance that the knowledge base of obstetricians was scientific and thus superior to the experience and intuitiveness of midwives, which hence became devalued (Belenky *et al.*, 1986, Cahill, 2001). This resulted in control of care during childbirth being transferred from midwives to obstetricians.

This thesis has demonstrated that midwives now have the opportunity to change this situation by working as MPs and extend their role to provide a midwifery model of care for women, regardless of risk status. However, if midwives are to assume these additional responsibilities, there is a need for them to overcome their reluctance to accept more autonomy in their practice.

APPENDIX - 1

Glossary of Terms

A4C	A reconfiguration of the system for remuneration of NHS staff (excluding doctors and dentists).
Cardiotocograph (CTG)	Continuous monitoring synstem of the fetal heart and uterine activity.
Clinical grades (eg E, F, G)	Old midwifery payscales, prior to the new bandings resulting from *Agenda for Change*
Intrapartum	Refers to the time during labour and birth
Junior Doctor	A doctor in a junior training post, who rotates to different units every four months. Also referred to as Senior House Officer (SHO). In obstetrics junior doctors are either career obstetrician/gynaecologists or trainee general practitioners.
Knowledge and Skills Framework	A mechanism where staff can progress on the career ladder by advancing their knowledge and skills.
Link midwives	Midwives in the units where this study was undertaken, who assisted the researcher with recruitment.
Maternity Support Worker (MSW)	Unregistered member of the midwifery workforce, who provide the more basic aspects of the midwives role. Also referred to as Health Care Assistants or Auxiliaries.
Middle Grade	A doctor who is second on call, who is senior to the junior doctor, but junior to the consultant. Also referred to as Specialist Registrars (SpR) and Registrars.
Ventouse/vacuum delivery	Operative delivery system, which uses a suction cup attached to the baby's head in order to expedite the birth.

APPENDIX – 2

Table of key dates in the history of midwifery

1486	The Malleus Maleficarum or the Hammer of Witches, the church had a misogynistic attitude to women and saw childbirth and women's sexuality as evil, this resulted in many midwives being burnt as witches.
1511	Doctors and Surgeons Act was passed and as a result of alleged concerns about incompetent midwifery practise doctors became involved in examining midwives knowledge.
1567	Eleanor Pead became the first midwife to be licensed by the archbishop of Canterbury.
1662	The education and licensing of midwives stopped and they were only required to pay a fee and take an oath to the Doctors Commons' to practise.
1663	The attendance of a male physician called Boucher on Louise De La Valliere, the mistress of Louise XIV, lead to the proliferation of male physicians into midwifery.
17th Century	Obstetric forceps invented by the Chamberlens, forceps were described as surgical instruments and as women were not allowed to join the Guild of the Barber Surgeons they were not allowed to use them, thus men found a niche in what had been a female dominated profession.
1671	The first midwifery book was written by a midwife, *The Midwives Book* by Jane Sharp.
1745	The Company of Surgeons split from the Barbers in 1800 and became the Royal College of Surgeons.
1747	The first lying-in beds were opened in a general hospital, at the Middlesex Hospital.
1750	Formal training of midwives began at Queen Charlottes Hospital.
1813	Proposals for midwifery legislation began, which were not successful until 1902.
1900	The Midwives Bill was passed on the third reading.
1902	The Midwives Act came into being and the Central Midwives Board was established. The Act licensed midwives to practise normal midwifery and ensured that they should be able to recognise deviations from the norm and call for medical assistance.
1948	The NHS was established.
1970	*The Peel Report,* DoH, recommended 100% hospital births.
1972	The Committee on Nursing was appointed by the Health Department and recommended the abolition of direct entry training for midwives. However, this continued in a few institutions throughout England and Wales and is now increasing.
1980	*The Short Report,* which was set up the Maternity Services Advisory Committee, recommended that better use should be made of the skills of midwives.

1983	The United Kingdom Central Council for Nurses, Midwives and Health Visitors, took over the function of the CMB.
1985	*Having a Baby in Europe*, WHO, highlighted the effects of medicalised and fragmented patterns of maternity care.
1986	*The Vision*, AIMS, stressed the necessity for maternity services to be responsive to women's needs and highlighted the frustration felt by midwives at the erosion of their role.
1987	*Towards a Healthy Nation*, RCM, reiterated the recommendations of 'The Vision'.
1991	*Junior Doctors: The New Deal*, NHSME, called for a reduction in hospital doctors' working hours.
1991	*The Protocol for Investment in Health Gain, Maternal and Early Child Health*, WHPF, recommended a reduction in interventions during childbirth.
1992	*The Winterton Report*, HoC, recommended a return to normality in care during childbirth and a greater role for midwives.
1992	The *Scope of Professional Practice,* UKCC, stated that midwives could cross professional barriers to improve care.
1993	*The Changing Childbirth Report*, DoH, recommended more choice, control and continuity for women in maternity care and the full utilisation of the midwives role.
1993	*Hospital Doctors: Training for the Future*, DoH, called for an increase in length of specialist medical training.
1998	*The European Working Time Directive,* DoH called for a reduction in working hours, but this did not apply to junior doctors.
1998	*Midwifery: Delivering our Future*, DoH, recommended that midwives develop their role in different ways, with some providing care for women in the low-risk category and others working with obstetricians to provide care for women at high–risk of developing complications.
1999	*Realising the Potential,* NAW, recommended the development of existing and the creation of new career pathways for nurses, midwives and health visitors.
1999	*Making a Difference,* WAG, opened the debate on innovations in practice.
2002	*Deliverng the Future in Wales*, WAG, recommended a return to normality and recommended that midwives develop their role to its full potential.
2002	The Nursing and Midwifery Council took over from the UKCC.
2003	Working Time Directive, NHSE, stated that doctors in training could work no more than forty-eight hours per week, which could be averaged over seventeen weeks.

For references see 1.2 and 2.2.1.

APPENDIX - 3

Audit of Midwife Practitioners in Wales

	Trust 1	Trust 2	Trust 3	Trust 4	Trust 5	Trust 6	Trust 7
No. of MPs employed	3 wte	5 wte	6 wte	4 wte	4 (3.4 wte)	4 (3.5 wte)	3.6 wte
Title	Midwife practitioner	Practice development midwife	Midwifery Practitioners	Gynae/ Midwifery Practitioners	Obstetric & Gynaecology Practitioners	Senior midwife clinical practice	Midwives in advanced clinical practice
Duties undertaken by MPs:							
Carry 1st on-call bleep	Yes	Yes	No	Yes	Yes	Yes	Yes
Respond to emergency obstetric bleep	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Work directly with on-call middle grade by night	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Initial assessment of patients admitted via:							
A & E	Yes	Yes	Yes	Yes	Yes	Yes	Yes
GP referral	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Direct L/W referral	Yes	Yes	Yes	No	Yes	Yes	Yes
Transfer from birth centre	Yes	Yes	Yes	No	Yes	Yes	No
Transfer in utero from other Trusts	Yes	Yes	Yes	No	Yes	Yes	N/A
In-house referrals from other specialities	Yes	Yes	Yes	No	Occasionally	Rarely	Possible
Practices undertaken:							
Cannulation	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Vepuncture	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Fetal blood sampling	To undertake training	No	No	No	Yes - training	To undertake training	No
Ventouse delivery	To undertake training	No	No	No	No	To undertake training	No
ECG	Yes	Yes	No	No	Yes	Yes	Yes
IV drug therapy	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Physical	Yes	Yes	Yes	Yes	Yes	Yes	Yes

examination of clients							
Consent for surgical procedures	Yes	No	No	No	No	No	No
Consent for sensitive disposal of PoC	Yes	Yes	Yes	No	No – done by gynae staff	No (under review)	No
Consent for post mortem of fetus/stillbirth	Yes	Yes	Yes	No	Yes	No	No
Interpretation of lab results	Yes	Yes	Yes	No	Yes	Yes	Yes
Assist at emergency obstetric surgery	Yes	Yes	Yes	Yes (C/S only)	Yes	Yes	Yes
Assist at elective obstetric surgery	Yes	Yes	Yes	Yes (C/S only)	Infrequently	No	No
Assist at emergency gynae surgery	Yes	Yes	No	Yes	Yes	Yes	Yes
Assist at elective gynae surgery	Yes	No	No	No	Infrequently	No	No
Cover role of SHO by day	Yes	To cover sickness, study leave & teaching	No	Occasionally to cover sickness	No due to sickness	No	No
Review of in-patients presenting with clinical symptoms :							
Obstetrics	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gynaecology	Yes	Yes	No	Yes	Yes	Yes	Yes

Adapted from audit of MPs in Wales, prepared for Heads of Midwifery Advisory Group, 2008.

APPENDIX - 4

Key Stakeholders consulted in the preparation of this thesis

Name	Job Title	Organisation	Consulted on:
Mrs. Polly Ferguson	Nursing Officer	WAG	Healthcare policy
Dr. Simon Young	Senior Lecturer	University of Glamorgan	Nurse prescribing
Dr. Alison Lipp	Principal Lecturer	University of Glamorgan	Reflexivity
Mrs. Nancy Thomas	Head of Midwifery Education	University of Glamorgan	Nurse practitioners and Relationship between doctors and midwives/ nurses
Mrs. Ruth Walker	Director of Nursing	Cwm Taf NHS Trust	Healthcare policy and Nurse Practitioners
Mr. Steven Vine	Clinical Director – Obstetrics, Gynaecology and Sexual Health	Cwm Taf NHS Trust	Healthcare Policy
Heads of Midwifery Advisory Group	Heads of Midwifery	All Wales Group	General discussions regarding thesis

APPENDIX – 5

Ethics committee letters

UNIVERSITY OF GLAMORGAN
PRIFYSGOL MORGANNWG

School of Care Sciences
Pontypridd CF37 1DL
Telephone 01443 483094
Fax 01443 483095
Professor Donna M Mead
Head of School
Email: dmead@glam.ac.uk

29th November 2002

Our ref: MG/SECjdaviesphd/eb.

Mrs J Davies
18 Hollybush Grove
Porth
CF39 9UG

Dear Mrs Davies,

Re: PhD Proposal.

The protocol for your proposal has been considered by the executive sub group and it was noted that external ethical approval will be sought in due course. The School Ethics Committee (SEC) is therefore, happy to allow the protocol to proceed to consideration by the Departmental Research Programmes Committee (DRPC).

On receipt of confirmation of ethical approval, I would appreciate it if you would provide SEC with a copy for our records.

Your sincerely,

Professor Margaret Griffiths (Chair)
School of Care Sciences

Letter sent to LREC x5 on 4-7

Multi-Centre Research Ethics Committee for Wales

Chairman/Cardeirydd: Dr John Saunders

MREC for WALES

Pwyllgor Ymchwil Ethegau Aml-Ganolfan yng Nghymru

Administrator/Gweinyddes: Corinne Scott

Temple of Peace and Health, Cathays Park, Cardiff CF10 3NW
Teml Heddwch ac Iechyd, Parc Cathays, Caerdydd CF10 3NW

WHTN 0 1809 Telephone enquiries to: 029 2040 2455 Fax No. 029 2040 2504

MREC website: http://www.corec.org.uk
e-mail : corinne.scott@bro-taf-ha.wales.nhs.uk

Mrs. Jacqueline Davies,
18 Hollybush Grove,
Llywncelyn,
Porth,
Rhondda,
RCT CF39 9UG

February 21st 2003

Dear Mrs. Davies,

MREC 03/9/11 **PLEASE QUOTE THIS IN ALL CORRESPONDENCE**
To what extent will Advanced Midwife Practitioners alter the role and function of midwifery?

I have reviewed the documents submitted in response to the MREC for Wales decision made at its meeting held on February 6th 2003, and set out in our letter dated February 7th 2003.

The documents reviewed were as follows:
At initial review :

- Full Application Form
- Invitation letter, dated December 2002
- Participant Information sheet – Phase I Focus Groups – version 2 dated December 2002
- Consent Form – Phase I - version 2 dated December 2002
- Topic Guide – Phase I - version 2 dated December 2002
- Participant Information Sheet – Phase II Participant Observation - version 2 dated December 2002
- Consent Form – Phase II - version 2 dated December 2002
- Participant Information Sheet for Childbearing Women – Phase II Participant Observation - version 2 dated December 2002
- Client Consent Form – Phase II - version 2 dated December 2002
- Staff Information Sheet – Phase II Participant Observation - version 2 dated December 2002
- ~~Staff Consent Form – Phase II Participant Observation - version 2 dated December 2002~~ **Superseded**
- Postnatal Women Participant Information Sheet – Phase III Interviews - version 2 dated December 2002
- Midwives / Obstetricians Participant Information Sheet – Phase III Interviews - version 2 dated December 2002
- Consent Form – Phase III – version 2 dated December 2002
- Phase III Interviews – Interview Schedule – version 2 dated December 2002
- ~~Phase III Interviews – Midwives / Obstetricians – version 2 dated December 2002~~ **Superseded**

- Letter to Obstetric Consultants – Phase III Interviews – version 2 dated December 2002
- Letter to GP – Phase III Interviews – version 2 dated December 2002
- Curriculum Vitae for Principal Investigator, Mrs. Jacqueline Davies

By Chairman :

- Staff Consent Form – Phase II Participant Observation - version 3 dated February 2003
- Phase III Interviews – Midwives / Obstetricians – version 3 dated February 2003

As Chairman, acting under delegated authority, I am satisfied that these accord with the decision of the Committee and agree that there is no objection on ethical grounds to the proposed study. I am, therefore, happy to give you our approval on the understanding that you will follow the conditions of approval set out below. A full record of the review undertaken by the MREC is contained in the attached MREC Response Form. The project must be started within three years of the date on which MREC approval is given.

- You must follow the protocol agreed and any changes to the protocol will require prior MREC approval.

- If projects are approved before funding is received, the MREC must see, and approve, any major changes made by the funding body. The MREC would expect to see a copy of the final questionnaire before it is used.

- You must promptly inform the MREC and appropriate LRECs of:

(i) deviations from or changes to the protocol which are made to eliminate immediate hazards to the research subjects;
(ii) any changes that increase the risk to subjects and/or affect significantly the conduct of the research;
(iii) all adverse drug reactions that are both serious and unexpected;
(iv) new information that may affect adversely the safety of the subjects or the conduct of the trial.

- You must complete and return the standard progress report form to the MREC one year from the date on this letter and thereafter on an annual basis. This form should also be used to notify the MREC when your research is completed.

While the MREC has given approval for the study on ethical grounds, it is still necessary for you to obtain management approval from the relevant Clinical Directors and/or Chief Executive of the Trusts (or Health Boards/HAs) in which the work will be done.

LREC Review

When undertaking the review of your project the MREC observed that this study falls under the Supplementary Operational Guidelines for NHS Research Ethics Committees, published in November 2000. This study is classed as Category D research, and therefore does not require LREC review.

For this reason you are asked to only inform the appropriate LREC of the project by sending a copy of this letter and also **giving the name and contact details of the local clinician involved.** If (unusually) the LREC has any reason to doubt that the local clinician is competent to carry out the tasks required, it will inform the clinician and the MREC that gave ethical approval giving full reasons.

You are not required to wait for confirmation from the LREC before starting your research.

Whilst the MREC would like as much information as possible about local sites at the time you apply for ethical approval it is understood that this is not always possible. You are asked, however, to send details of local sites as soon as a researcher has been recruited. This is essential to enable the MREC to monitor the research it approves.

The MRECs are fully compliant with the International Conference on Harmonisation/Good Clinical Practice (ICH GCP) Guidelines for the Conduct of Trials Involving the Participation of Human Subjects as they relate to the responsibilities, composition, function, operations and records of an Independent

Ethics Committee/Independent Review Board. To this end it undertakes to adhere as far as is consistent with its Constitution, to the relevant clauses of the ICH Harmonised Tripartite Guideline for Good Clinical Practice, adopted by the Commission of the European Union on 17 January 1997. The Standing Orders and a Statement of Compliance were included on the computer disk containing the guidelines and application form and are available on request or on the Internet at http://www.corec.org.uk

Yours sincerely,

Dr. John Saunders
Chairman
MREC for Wales

APPENDIX - 6

Version – 3, December 2003

PHASE 1- FOCUS GROUPS

PARTICIPANT INFORMATION SHEET

Dear .....,

Re: Blurring the Boundaries Between Midwifery and Obstetrics: An Exploration of the Role of Midwife Practitioner

Introduction

I am a PhD student at the University of Glamorgan and I would like to invite you to take part in my study, which explores the role of Midwife Practitioners. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read this information sheet and discuss it with others if you wish. Contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you would like to take part.

What is this study about?

Opportunities have been given to midwives to develop their role by carrying out duties traditionally undertaken by doctors, and work as Midwife Practitioners. The role of Midwife Practitioner is a relatively new development and there has not been a great deal of research on this topic. An increased understanding of this subject may lead to more effective planning when developing services for childbearing women. One of the aims of this study is to understand how midwives perceive their role and function during the provision of intrapartum care. To explore this, six focus groups of 5-10 midwives will be held in maternity units throughout South Wales.

Why you have been chosen?

One of the aims of this study is to find out the views of midwives about their role in the provision of intrapartum care. To achieve this it is necessary to obtain the views of midwives of various grades and experience who provide intrapartum care. You have been identified as a midwife who fits the criteria and therefore you are in an ideal position to provide this information.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

What you will have to do if you take part?

You will have to attend a focus group, which will be held in your unit, within your working hours, to discuss your perceptions about the role and function of midwives during the intrapartum period. The focus group will last approximately two hours and will be tape-recorded. All information will be anonymised. This is so the researcher has a record of what was said. As soon as the study has been completed the tapes will be destroyed. The main topics of the focus group will be: the essential functions of midwives, the influencing factors on their role and others perceptions of the midwives role.

What are the possible disadvantages of taking part?

Discussing your experience of cases may raise issues that you would want to discuss further. If this occurs you can discuss these issues with your Supervisor of Midwives.

What are the possible benefits of taking part?

Although the research study will not directly benefit you it is hoped that it will provide guidance for those who plan midwifery services for the future direction of the profession.

Will your contribution be kept confidential?

You will not be identified in any way, in the unit or in any written documents resulting from this study and you will not be obliged to disclose information, which you would prefer to keep private.

What will happen to the information you provide?

It will be used to support a range of data gathered from different individuals interested in Midwife Practitioners and you will be given the opportunity to comment on the aspect you have been involved in. The data will be used for a research study.

What now?

If you decide to take part in the study please sign the consent forms, returning one to the researcher in the freepost envelope provided, keeping one copy for yourself. I will then contact you to arrange a suitable time for the focus group. Thank you for taking the time to read this information sheet.

If you require any further information about this study please contact the researcher.

Mrs. Jacqueline Davies
Maternity Unit
Address
Telephone Number

Version – 3, December 2003

PHASE 2 - PARTICIPANT OBSERVATION

PARTICIPANT INFORMATION SHEET FOR MIDWIFE PRACTITIONERS

Dear .....,

Re: Re: Blurring the Boundaries Between Midwifery and Obstetrics: An Exploration of the Role of Midwife Practitioner.

Introduction

I am a PhD student at the University of Glamorgan and I would like to invite you to take part in my study, which explores the role of Midwife Practitioners. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read this information sheet and discuss it with others if you wish. Contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you would like to take part.

What is this study about?

Opportunities have been given to midwives to develop their role by carrying out duties traditionally undertaken by doctors, and work as Midwife Practitioners. The role of Midwife Practitioner is a relatively new development and there has not been a great deal of research on this topic. An increased understanding of this subject may lead to more effective planning when developing services for childbearing women.

Why you have been chosen?

The purpose of this study is to examine the role of Midwife Practitioners. As you are employed in this capacity you are in an ideal position to provide this information.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

What you will have to do if you take part?

When new midwifery posts are developed it is important to assess their impact on both patient care and on the profession generally. The aim of this study is to gain an understanding of the impact of this extension of the midwives role on the way in which you work and interact with both members of the professional team and childbearing women. One way of doing this is to undertake, participant observation in maternity units.

The main activity of the researcher will be to observe you over a period of fourteen days. Women who may be in-patients during the time the researcher will be present on the unit, will receive a letter during the antenatal period explaining about the study. They will have the opportunity to refuse to have the researcher present if they wish. If you decide to take part, the researcher will accompany you during shifts where

clinical care is provided, and will include times when you are providing both patient care and when you are liaising with other members of the professional team. During the period of observation there will also be a series of interviews to discuss your role, at times that suit you. These interviews will be tape-recorded. As soon as the study has been completed the tapes will be destroyed. The researcher will not undertake any midwifery care and if at any time it is inappropriate to have the researcher present she will leave. The period of observation will be fourteen shifts over an eight-week period.

What are the possible disadvantages of taking part?

Discussing your experience of working as a Midwife Practitioner may raise issues that you would want to discuss further. If this occurs you can discuss these issues with your Supervisor of Midwives.

What are the possible benefits of taking part?

Although the research study will not directly benefit you it is hoped that it will provide guidance for those who plan midwifery services for the future direction of the profession.

Will your contribution be kept confidential?

You will not be identified in any way in any written documents resulting from this study and you will not be obliged to disclose information, which you would prefer to keep private.

What will happen to the information you provide?

It will be used to support a range of data gathered from different individuals interested in Midwife Practitioners and you will be given the opportunity to comment on the aspect you have been involved in. The data will be used for a research study.

What now?

If you decide to take part in the study please sign the consent forms, returning one to the researcher in the freepost envelope provided, keeping one copy for yourself. I will then contact you to arrange a suitable time for the observation period. Thank you for taking the time to read this information sheet.

If you require any further information about this study please contact the researcher.

Mrs. Jacqueline Davies
Maternity Unit
Address
Telephone Number

Version – 3, December 2003

PHASE 2 - PARTICIPANT OBSERVATION

PARTICIPANT INFORMATION SHEET FOR CHILDBEARING WOMEN

Dear Madam,

Re: Re: Blurring the Boundaries Between Midwifery and Obstetrics: An Exploration of the Role of Midwife Practitioner

Introduction

I am a PhD student at the University of Glamorgan and a qualified midwife working for North Glamorgan NHS Trust. As part of my research study I will be observing the work of the Midwife Practitioners. This will take place during the period when you are due to have your baby. I would like to ask your consent to be present when you are in the unit and receiving care and also to look at your case notes. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read this information sheet and discuss it with others if you wish. Contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you would like to take part.

What is this study about?

Opportunities have been given to midwives to develop their role by carrying out duties traditionally undertaken by doctors, and work as Midwife Practitioners. The role of Midwife Practitioner is a relatively new development and there has not been a great deal of research on this topic. An increased understanding of this subject may lead to more effective planning when developing services for childbearing women.

Why you have been chosen?

Audit of the Midwife Practitioner role has shown that it is both safe and effective. The purpose of this study is to explore the role of Midwife Practitioners. During the time you are due to have your baby I will be working with these midwives and if you are cared for by them I would like to be present.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

What you will have to do if you take part?

You will allow the researcher to be present if you are receiving care from the Midwife Practitioners. With your permission the researcher will look at your case notes. All information will be anonymous and will not affect any care you receive now or in the future.

What are the possible disadvantages of taking part?

You may not want to have any unnecessary staff present at this time, and you may wish to discuss this issue with your midwife. You can ask the researcher to leave at any time.

What are the possible benefits of taking part?

Although the research study will not directly benefit you it is hoped that it will provide guidance for those who plan midwifery services for the future direction of the profession.

Will your contribution be kept confidential?

You will not be identified in any way, in the unit or in any written documents resulting from this study.

What will happen to the information gathered from the period of observation?

It will be used to support a range of data gathered from different individuals interested in Midwife Practitioners. This data will be used for a research study.

What now?

If you decide to take part in the study please sign the consent forms, returning one to the antenatal clinic when you next attend, keeping one copy for yourself. Thank you for taking the time to read this information sheet.

If you require any further information about this study please contact the researcher.

Mrs. Jacqueline Davies
Maternity Unit
Address
Telephone Number

Version – 3, December 2003

PHASE 2 - PARTICIPANT OBSERVATION

STAFF INFORMATION SHEET

Re: Re: Blurring the Boundaries Between Midwifery and Obstetrics: An Exploration of the Role of Midwife Practitioner

Introduction

I am a PhD student at the University of Glamorgan and I would like to invite you to take part in my study, which explores the role of Midwife Practitioners. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read this information sheet and discuss it with others if you wish. Contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you would like to take part.

What is this study about?

Opportunities have been given to midwives to develop their role by carrying out duties traditionally undertaken by doctors, and work as Midwife Practitioners. The role of Midwife Practitioner is a relatively new development and there has not been a great deal of research on this topic. An increased understanding of this subject may lead to more effective planning when developing services for childbearing women.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

What will your involvement be?

The aim of this study is to explore the role of Midwife Practitioner. One way of doing this is to undertake, participant observation in maternity units.

The main activity of the researcher will be to observe the Midwife Practitioners over a period of eight shifts. You may be on duty during this time and be providing care for women who the Midwife Practitioner will also be caring for. In such cases the researcher would like to be present.

What are the possible disadvantages of taking part?

Having the researcher present when you are providing care may make you feel uncomfortable. If this occurs you can ask the researcher to leave or discuss this with your Supervisor of Midwives.

What are the possible benefits of taking part?

Although the research study will not directly benefit you it is hoped that it will provide guidance for those who plan midwifery services for the future direction of the profession.

Will your contribution be kept confidential?

You will not be identified in any way in any written documents resulting from this study and you will not be obliged to disclose information, which you would prefer to keep private.

What will happen to the information gathered?

It will be used to support a range of data gathered from different individuals interested in Midwife Practitioners. The data will be used for a research study.

What now?

If you decide to take part in the study please sign the consent sheet. Thank you for taking the time to read this information sheet.

If you require any further information about this study please contact the researcher.

Mrs. Jacqueline Davies
Address
Maternity Unit
Telephone Number

Version – 3, December 2003

PHASE 3 - INTERVIEWS

PARTICIPANT INFORMATION SHEET FOR POSTNATAL WOMEN

Dear .....,

Re: Re: Blurring the Boundaries Between Midwifery and Obstetrics: An Exploration of the Role of Midwife Practitioner

Introduction

I am a PhD student at the University of Glamorgan and I would like to invite you to take part in my study, which explores the role of Midwife Practitioners. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read this information sheet and discuss it with others if you wish. Contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you would like to take part.

What is this study about?

Opportunities have been given to midwives to develop their role by carrying out duties traditionally undertaken by doctors, and work as Midwife Practitioners. The role of Midwife Practitioner is a relatively new development and there has not been a great deal of research on this topic. An increased understanding of this subject may lead to more effective planning when developing services for childbearing women.

Why you have been chosen?

The purpose of this aspect of the study is to find out the views of midwives, doctors and childbearing women about the impact of the Midwife Practitioners role. As you have been cared for by Midwife Practitioners you are in an ideal position to provide this information.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

What you will have to do if you take part?

You will have an interview to discuss some of these issues with the researcher. This can be in your home or the Maternity Unit. If you need to travel your expenses will be paid. This interview will last approximately one hour and with your permission will be tape-recorded. This is so the researcher has a record of what was said, as soon as my study has finished the tapes will be destroyed. All information will be anonymous and will not affect any care you receive now or in the future. The main topics, which will be discussed, are: the role and status of midwives, the impact of Midwife Practitioners on the doctor's role and on patient care and the future development of the midwives role.

What are the possible disadvantages of taking part?

Discussing your experience of childbirth may raise issues that you would want to discuss further. If this occurs you can discuss these issues with your midwife or General Practitioner.

What are the possible benefits of taking part?

Although the research study will not directly benefit you it is hoped that it will provide guidance for those who plan midwifery services for the future direction of the profession.

Will your contribution be kept confidential?

You will not be identified in any way, in the unit or in any written documents resulting from this study and you will not be obliged to disclose information, which you would prefer to keep private.

What will happen to the information you provide?

It will be used to support a range of data gathered from different individuals interested in Midwife Practitioners and you will be given the opportunity to comment on the aspect you have been involved in. This data will be used for a research study.

What now?

If you decide to take part in the study please sign the consent forms, returning one to the researcher in the freepost envelope provided, keeping one copy for yourself. I will then contact you to arrange a suitable time for an interview. Thank you for taking the time to read this information sheet.

If you require any further information about this study please contact the researcher.

Mrs. Jacqueline Davies
Address
Maternity Unit
Telephone Number

Version – 3, December 2003

PHASE 3 - INTERVIEWS

PARTICIPANT INFORMATION SHEET FOR MIDWIVES/OBSTETRICIANS

Dear .....,

Re: Re: Blurring the Boundaries Between Midwifery and Obstetrics: An Exploration of the Role of Midwife Practitioner

Introduction

I am a PhD student at the University of Glamorgan and I would like to invite you to take part in my study, which explores the role of Midwife Practitioners. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read this information sheet and discuss it with others if you wish. Contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you would like to take part.

What is this study about?

Opportunities have been given to midwives to develop their role by carrying out duties traditionally undertaken by doctors, and work as Midwife Practitioners. The role of Midwife Practitioner is a relatively new development and there has not been a great deal of research on this topic. An increased understanding of this subject may lead to more effective planning when developing services for childbearing women.

Why you have been chosen?

The purpose of this aspect of the study is to find out the views of midwives, doctors and childbearing women about the impact of the Midwife Practitioners role. As you have had experience in a unit where Midwife Practitioners work you are in an ideal position to provide this information.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

What you will have to do if you take part?

You will have to attend an interview to discuss some of these issues with the researcher, in the Maternity Unit, this will be held within your working hours. This interview will last approximately one hour and with your permission will be tape-recorded. This is so the researcher has a record of what was said, as soon as my study has finished the tapes will be destroyed. All information will be anonymous. The main topics which will be discussed, are: the role and status of midwives, and the impact of Midwife Practitioners on midwives and obstetricians in the unit.

What are the possible disadvantages of taking part?

Discussing your experience of cases may raise issues that you would want to discuss further. If this occurs you can discuss these issues with your Supervisor of Midwives or manager.

What are the possible benefits of taking part?

Although the research study will not directly benefit you it is hoped that it will provide guidance for those who plan midwifery services for the future direction of the profession.

Will your contribution be kept confidential?

You will not be identified in any way in any written documents resulting from this study and you will not be obliged to disclose information, which you would prefer to keep private.

What will happen to the information you provide?

It will be used to support a range of data gathered from different individuals interested in Midwife Practitioners and you will be given the opportunity to comment on the aspect you have been involved in. This data will be used for a research study.

What now?

If you decide to take part in the study please sign the consent forms, returning one to the researcher in the freepost envelope provided, keeping one copy for yourself. I will then contact you to arrange a suitable time for an interview. Thank you for taking the time to read this information sheet.

If you require any further information about this study please contact the researcher.
Mrs. Jacqueline Davies
Address
Maternity Unit
Telephone Number

APPENDIX – 7

Version – 3, December 2003

CONSENT FORM – PHASE 1

Re: Blurring the Boundaries Between Midwifery and Obstetrics: An Exploration of the Role of Midwife Practitioner

	(Please Sign)
I confirm that I have read and understood the information sheet for focus groups, dated December 2003, for the above study (please keep the accompanying copy).	_____
I confirm that I have received enough information about the study and have had the opportunity to ask questions.	_____
I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason. A decision to withdraw at any time, or a decision not to take part will not affect me in any way.	_____
I understand that my name will not be mentioned or identified in any way in written reports and that all records will be kept confidential.	_____
I agree to take part in the above study.	_____
I agree to the tape recording of the focus group.	_____

PARTICIPANT

Signed ----------

Date ----------

Name (Block Letters) ----------

Work Address ----------

Telephone Number ----------

INVESTIGATOR

The above participant has indicated his/her willingness to participate in this study

Signed ---------- Name (Block Letters)----------

Date ----------

Version – 3, December 2003

MIDWIFE PRACTITIONER CONSENT FORM - PHASE 2

Re: Blurring the Boundaries Between Midwifery and Obstetrics: An Exploration of the Role of Midwife Practitioner

(Please Sign)

I confirm that I have read and understood the information sheet for participant observation, dated December 2003, for the above study (please keep the accompanying copy). _____

I confirm that I have received enough information about the study and have had the opportunity to ask questions. _____

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving giving any reason. A decision to withdraw at any time, or a decision not to take part will not affect me in any way. _____

I understand that my name will not be mentioned or identified in any way in written reports and that all records will be kept confidential. _____

I agree to take part in the above study. _____

I agree to the tape recording of interviews. _____

I agree to being observed while on duty. _____

PARTICIPANT

Signed ---------- Name (Block Letters)----------

Date ----------

Work Address ----------

Telephone Number ----------

INVESTIGATOR

The above participant has indicated his/her willingness to participate in this study

Signed ---------- Name (Block Letters)----------

Date ----------

Version – 3, December 2003

STAFF CONSENT FORM – PHASE 2

Re: Blurring the Boundaries Between Midwifery and Obstetrics: An Exploration of the Role of Midwife Practitioner

I confirm that I have read and understood the information sheet for participant observation, dated December 2003, for the above study.

I confirm that I have received enough information about the study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason. A decision to withdraw at any time, or a decision not to take part will not affect me in any way.

I understand that my name will not be mentioned or identified in any way in written reports and that all records will be kept confidential.

I agree to take part in the above study by being observed while on duty.

PARTICIPANTS

NAME	SIGNATURE	DATE

Version – 3, December 2003

CLIENT CONSENT FORM – PHASE 2

Re: Blurring the Boundaries Between Midwifery and Obstetrics: An Exploration of the Role of Midwife Practitioner

(Please Sign)

I confirm that I have read and understood the information sheet for participant observation, dated December 2003, for the above study (please keep the accompanying copy). _____

I confirm that I have received enough information about the study and have had the opportunity to ask questions. _____

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason. _____

I understand that my name will not be mentioned or identified in any way in written reports and that all records will be kept confidential. _____

I agree to take part in the above study. _____

I agree to the researcher being present When I am receiving care. _____

I agree to allow the researcher access to my case notes. _____

PARTICIPANT

Signed ---------- Name (Block Letters)----------

Date ----------

Home Address ----------

Telephone Number ----------

INVESTIGATOR

The above participant has indicated his/her willingness to participate in this study

Signed ---------- Name (Block Letters)----------

Date ----------

Version – 3, December 2003

CONSENT FORM – PHASE 3

Re: Blurring the Boundaries Between Midwifery and Obstetrics: An Exploration of the Role of Midwife Practitioner

	(Please Sign)
I confirm that I have read and understood the information sheet for interviews, dated December 2003, for the above study (please keep the accompanying copy).	_____
I confirm that I have received enough information about the study and have had the opportunity to ask questions.	_____
I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason. A decision to withdraw at any time, or a decision not to take part will not affect me in any way.	_____
I understand that my name will not be mentioned or identified in any way in written reports and that all records will be kept confidential.	_____
I agree to take part in the above study.	_____
I agree to the tape recording of interview.	_____

PARTICIPANT

Signed ----------

Date ----------

Name (Block Letters) ----------

Work/Home Address ----------

Telephone Number ----------

INVESTIGATOR

The above participant has indicated his/her willingness to participate in this study

Signed ---------- Name (Block Letters)----------

Date ----------

APPENDIX - 8

Version – 3, December 2003

PHASE ONE TOPIC GUIDE

General Issues

- Introduction
- Consent, Confidentiality, Tape Recorder
- Explanation about the project
- What happens in a focus group
- Role of moderator and note-taker
- Explanation that all questions are about the midwives role in the intrapartum period
- Ask participants to say their name, where they are from, and one interesting thing about themselves (for the tape)

Essential functions of midwives

- Why did you become a midwife.
- What do women want from their midwife when they are in labour
- What are the main aspects of intrapartum care, that can only be done by a midwife.
- What aspects of intrapartum care currently undertaken by midwives, can be done by other staff, such as doctors, nurses or support staff.
- What are the **most important** midwifery functions undertaken in providing care for women in labour.

Perceptions about midwives

- How would midwives describe their role during the intrapartum period.
- How does the general public perceive the role of the midwife.
- How does the media portray midwives.
- What do nurses think of midwives.
- What do obstetricians think of midwives.

Influencing factors on the role of the midwife

- How has the midwives role changed over the last hundred years - why has this happened.
- What things are influencing the role of the midwife now
- What do you know about the role of midwife practitioners
- How do you think the role of midwife practitioners will alter the midwives' role
- What do you think the midwives' role will be like in 50 years time.
- Any other relevant issues which should be raised.

Conclusion

- Summarise main points.
- Explanation of what happens next.

Version – 3, December 2003

PHASE TWO
INTERVIEW SCHEDULE FOR MIDWIFE PRACTITIONERS

General Issues

- Introduction.
- Consent, confidentiality, tape recorder.
- Explanation about the project.

Role and Status

- How would you describe your role?
- Why did you want to become a midwife practitioner?
- What are the main differences between working as a midwife and working as a midwife practitioner?
- Which team do you feel more a part of, midwives or obstetricians and why?
- What do you think are the advantages of developing midwife practitioner roles?
- What do you think are the disadvantages of developing midwife practitioner roles?
- Does the role retain the essence of what is midwifery? If so in what ways?
- Do you find there are pressures to undertake midwifery duties? Can you give some examples?
- Do you find there are pressures to undertake inappropriate medical duties? Can you give some examples?
- What are the functions of the midwife practitioners' role in the provision of intrapartum care?
- How has your clinical decision making changed since taking up this role?

Perceptions about Role

- How do midwives feel about midwife practitioners (how would they describe you)?
- Have you noticed any resentment from midwives, if so what form has this taken?
- How do SHO's, middle grades and consultant obstetricians feel about midwife practitioners?
- What sort of responses have you had from obstetricians?
- How do clients feel about midwife practitioners?
- What sort of responses have you had from clients and their families?
- How do you think this role affects the status of midwives?

Influencing Factors

- What factors are influencing the role of midwife practitioners?

- What do you think the role will be like in ten years time?
- What do you think are the implications for the midwifery profession of extending the midwives role in this way?
- What action does the profession need to take to protect the core aspects of the midwives' role?

Conclusion

- Is there anything else you would like to tell me about your experience of working as a midwife practitioner?

Version – 3, December 2003

Phase Two Midwife Practitioners' Diaries

Day 1

Thoughts and feelings about the shift just completed

Details of situations during the shift, which as a midwife practitioner, you have dealt with differently than you would as a clinical midwife

What was the most rewarding thing to happen during the shift?

What was the most challenging thing to happen during the shift?

Version – 3, December 2003

PHASE THREE INTERVIEWS

INTERVIEW SCHEDULE FOR MIDWIVES/OBSTETRICIANS

General Issues

- Introduction.
- Consent, Confidentiality, Tape Recorder.
- Explanation about the project.

Role and status of midwives

- How would you describe the role of the midwife?
- How would you describe the role of midwife practitioners?
- How do you think they have changed the midwives' role?
- How do you think they affect the status of midwives?
- How do you think midwife practitioners will develop in the future?
- Do you think the midwifery profession should be developing in this way?

Impact on the medical profession

- What are your views about midwife practitioners substituting for junior doctors?
- How do you think the establishment of this role has affected the volume of Obstetric Registrars work?
- What is your impression of the volume of work undertaken by midwife practitioners, compared with junior doctors?
- Do you think that midwife practitioners order more investigations than junior doctors?

Impact on patient care

- How do you think midwife practitioners have affected patient care?
- How do you feel about midwife practitioners providing care for gynaecological patients?
- What impact do you feel midwife practitioners have on intervention levels and medicalisation during childbirth?
- What impact do you think midwife practitioners have on normalising childbirth?
- Do you think they have enough training to carry out their role?
- Do midwife practitioners carry out any inappropriate tasks?

Impact of midwife practitioners on the maternity unit

- What would you say are the advantages of having midwife practitioners in the unit?

- What would you say are the disadvantages of having midwife practitioners in the unit?
- Have you witnessed any rivalry between the midwife practitioners and the other midwives?

Development of midwives' role

- What are the current factors influencing the midwives' role?
- How do you see the midwives' role developing in the future?
- What do you think are the implications for midwifery of extending the midwives' role?
- What action does the profession need to take to protect the core aspects of the midwives role?

Conclusion

- Is there anything else you would like to tell me about your experience of working with midwife practitioners?

Version – 3, December 2003

PHASE THREE INTERVIEWS

INTERVIEW SCHEDULE FOR POSTNATAL WOMEN

General Issues

- Introductions.
- Consent, Confidentiality, Tape Recorder.
- Explanation about project.
- Woman's experience of childbirth.

Role and status of midwives

- How would you describe the role of the midwife?
- What are your impressions about midwives from the media?
- What do you understand about the role of the Midwife Practitioner?

Impact on doctors' role

- How would you describe the role of doctors on the labour ward?
- How did you feel about being seen by a Midwife Practitioner rather than a doctor?
- Did you feel reassured that the Midwife Practitioners had the appropriate knowledge and skills to provide your care?

Impact on patient care

- What do you feel are the advantages of being cared for by a Midwife Practitioner?
- What do you feel are the disadvantages of being cared for by a Midwife Practitioner?
- Were you aware of any rivalry between the Midwife Practitioners and the other midwives?

Development of midwives' role

- Do you think midwives should be developing in this way?
- How do you think the midwives role differs from the image you had about midwives before having your baby?

Conclusion

- Is there anything else you would like to tell me about your experience of being cared for by Midwife Practitioners?

APPENDIX - 9

Fieldnotes from period of participant observation during Phase two

Week 1, Night 1 20/11/04 Sara

Five midwives on duty: teams - 1 sister and 1 staff midwife, core team - 1 sister and 1 staff midwife, midwifery led - 1 sister, also one health care assistant on duty. The midwives tend to stay on the ante/postnatal ward, only going to labour ward if there is a patient there.

The handover of care from the junior doctor to the midwife practitioner consisted of the bleep being passed from one to the other; no information about the activity on the unit or the condition of clients was given. The only thing the doctor said was that she would be in her room and her bleep number. The midwife practitioner said that this was the usual type of handover she received.

There was one patient (client a) on labour ward complaining of diminished fetal movements. The middle grade was already on labour ward, she and the midwife practitioner went in to see the patient. Sara's eyes looked concerned abut the fetal heart rate tracing, she said to the patient "let's sit you up, no don't move it's ok" and moved the bed electronically so the patient was sitting up. The doctor asked the patient a question about the fetal movements and looked at the trace, she didn't appear to have any reaction to it. Sara asked the patient what had been happening with her, but the woman was unable to answer at first because she was too nervous, after reassurance she said that she had been having pains and had not felt the baby moving. Sara said something reassuring to her and we left the room. **Theme - communication with women.**

At the nurses station she told the midwife and one of the other midwife practitioners about the trace and they went in one at a time to have a look at it and both agreed that it was suspicious. The midwife, who had been looking after the patient had not recognised this until then. The tracing gradually improved (probably due to the change in position) and the woman was moved to the antenatal ward. Sara wrote in the casenotes, the middle grade did not. **Theme - relationship with midwives.**

The phone rang and Sara answered it, it was a patient (client b) complaining of spontaneous rupture of membranes, Sara advised her to come in to be checked and arranged for a health care assistant to collect her notes from antenatal clinic. While this was happening the two midwives on duty were chatting. If it had been a doctor the midwives would have had to deal with this matter, but neither responded and seemed to think it was ok for Sara to do it. **Theme - relationship with midwives.**

The midwife left labour ward with the patient, told Sara that she was going and left with the assumption that Sara would stay on the labour ward while she was away. But the midwives seemed very friendly with Sara chatting and joking about patients; they seemed to relate well to her and automatically assumed that she would assist them,

although they would not expect this from medical staff. **Theme - relationship with midwives.**

Called to ward to give intravenous drugs, there was little communication from the staff midwife. On labour ward Sara was very much part of the midwifery team. It was noticeable that the medical staff also regarded her as part of their team. Sara drew up and checked drugs and went to see the woman (client c), the health care assistant, who had just finished washing the woman, asked Sara to check the woman's wound as she was concerned about oozing of blood from around the drain. Sara explained to the woman what she was doing and chatted in a friendly, informal way about the caesarean section and how the woman would feel much better the next day when she started moving around. On completion of this Sara went back to the midwife and discussed the case informing her that the wound was ok. **Themes – relationship with midwives, decision-making and planning care and communication with women.**

Sara told me that this midwife was always a bit cool towards them, she had apparently applied for one of the posts and had been unsuccessful, which may have explained her attitude.

We had a conversation with the junior doctor, he seemed very friendly, more so than I had seen him before, the conversation seemed to be on a more personal level. He asked what we knew about (name of hospital) as he had an interview coming up for his next job there and was concerned about this. **Theme – relationship with medical staff.**

While waiting for the next call Sara spoke of her keenness to develop services, we spoke of the environmental audit she wanted to carry out on the labour ward and how she hoped the midwives would become more confident and take on more responsibilities. **Themes – aspirations to develop services and midwives confidence and practice.**

Bleeped to attend the Accident and Emergency department, the junior doctor there asked about her role, as he was not aware of such posts and seemed genuinely interested. He told us briefly about the patient (client d), she was pregnant and had fainted. The only contact with nursing staff was when they said they had no cubicle for the patient and Sara insisted she could not see her in the waiting room and would need a private cubicle. When we eventually found her a cubicle in fracture clinic, Sara asked about what had brought her to hospital and it turned out that she had not eaten all day and had gone to town, drunk two cans of lager and fainted (it appeared that she had drunk a lot more than two cans). Sara examined her and explained the importance of eating regularly, ascertained that she had a follow up appointment and sent her home with instructions to eat something when she got home. Sara commented that the nurses used to ask her to take the patients up to the ward if they were admitted, but she declined, as this was not her job (it is the job of a nurse and a porter) and they wouldn't ask a doctor to do this, she said they don't ask anymore.

When we returned to the reception desk of the Accident and Emergency Department the department had become very busy, two soldiers accompanied a colleague who was on a trolley and looked as if he had been in an accident, while three police officers

brought in a young man who had blood streaming from his face. The staff seemed unfazed by both this and the radio, which was blaring out in the busy waiting room; the atmosphere was one of organised chaos, I realised that if I had been working there I would have had difficulty dealing with the chaos and noise of the department, but to the staff there it was just a normal night.

One of the junior doctors stopped and asked Sara about her recent holiday and they gossiped about one of the other doctors, again this seemed very friendly. **Theme – relationship with medical staff.**

We returned to labour ward to check a woman (client e) who had come in with a possible spontaneous rupture of membranes and abdominal pain. The midwifery sister said "I have done a speculum because you were in A and E, I couldn't see any liquor draining, but the amniostick was positive, it went black straight away, I've done a CTG trace if you want to see it". This was said as if she was justifying her decision to do it, although this was the appropriate thing to do, the midwives generally seemed keen to not exceed their role. **Theme – relationship with midwives.** In the room Sara checked the cardiotocograph trace and asked the woman about the pains, how often are they, since when have you had pain, what sort of pains are they? The woman replied that they were irregular and sharp. Sara then asked her about her loss," have you had wet pants"? Patient, "yeah", Sara "is it getting lighter"? patient, "not sure", Sara "does it get heavier when you have a pain"? patient, "not sure", Sara "check for me from now on ok, I think you need to stay in tonight and see how things are tomorrow, is that ok"? patient "yeah, but can I go and have a fag first", laughter, Sara "ok". **Themes – decision-making and planning care and communication with women.**

Sara returned to the nurses station and tells the midwife what she has decided, they discuss the case and Sara writes in notes. When the patient is taken to the ward Sara is again left on the labour ward, when the midwife returns Sara helps her make the bed. **Theme – relationship with midwives.**

We spent some time talking to staff and looking at things on the computer to pass the time while waiting for the next call.

1.30am had food and wrote up notes.

Sara commented that some middle grade doctors had concerns that their role would increase their workload, she felt that this might well be the case for instance "we can't prescribe so we will have to call them for each prescription". **Theme – relationship with medical staff.**

03.45 hrs called to ward by staff midwife to see a woman (client f) who had vomited 'coffee grounds' (old blood) and had abdominal pain. Sara saw the patient, asked details about the pain and history of vomiting, she examined the woman, the abdomen was soft, no obvious pain. Sara read the case notes and decided the middle grade doctor needed to see her. When she phoned her she complained, "where is the junior doctor? they can refer to a surgeon". Sara stated, "she needs to be seen by a middle grade". She reluctantly came and saw the patient, ordered Buscupan and said to

review in the morning. Sara had to remind her to write in the casenotes. **Themes – relationship with medical staff and decision-making and planning care.**

When the middle grade attended the ward she was obviously not happy about being called and was abrupt with Sara. The practitioners cannot deal with clients who present with problems, which are not obstetric or gynaecology related so the medical staff have to come and assess patients. Referrals to other specialities should be made by middle grades but it seems that this has been delegated to junior staff. Sara informed me that medical staff have not got used to working a shift system and stay up all day in the hope they will have a quiet night. Their attitudes to this will need to change as they are likely to be called more often due to the limitations in the scope of care the midwife practitioners can undertake, this may cause problems. **Theme – relationship with medical staff.**

There were no other calls during the night and we sat and chatted and drank tea with the staff on the gynaecology ward. I later found that they normally spend more time on the maternity dept. this may have had something to do with the staff on duty. **Theme - relationship with nursing/midwifery staff.**

Sara's handover consists of what has happened during the night, any problems and any work outstanding.

Comments

The midwife practitioners do what the midwives could do, but don't feel they have the authority or confidence to do. The midwife practitioners ask the direct questions and they make the decisions, it seems a strange situation that a midwife calls somebody else to do what she is capable of and defers to the midwife practitioner as the ultimate decision maker. **Themes – relationship with midwives and decision-making and planning care.** Their relationship with the medical staff is interesting, they seem to accept the midwife practitioner as one of their own and speak to them on a different level to the way they speak to the midwives, this was also apparent in the Accident and Emergency department, their conversations are more personal they relate to each other much better. **Theme – relationship with medical staff.** The midwife practitioners relationship with the midwives generally seem very good, the practitioners seem friendly and approachable and are prepared to assist the midwives, I think this is sometimes taken for granted on occasion, where the midwife practitioners are left on the labour ward while the midwives take women to the ward and when the phone rings the midwife practitioner is expected to answer it and deal with the problem, a junior doctor would not be expected to do this. **Theme – relationship with midwives.**

The midwife practitioners also seem to take more ownership of the area, wanting to improve services and the environment, whereas junior doctors are just passing through and tend not to have that level of commitment to the unit. **Theme – aspirations to develop services and midwives confidence and practice.** The way the midwife practitioners speak to the women is the same as the way the midwives speak to them, it's a general conversation between people on the same level, rather than a clinician making a diagnosis and ordering the management of care, they seem to relate to the women as human beings. **Theme – communication with women.**

When a midwife did a speculum examination, which she was allowed to do, she obviously felt uncomfortable about having done this and justified it by saying she had done it because the midwife practitioner had been busy, again she seemed to be deferring to the midwife practitioner. **Theme – relationship with midwives.** The midwife practitioner confirmed my opinions about the relationships, however, she wasn't sure about the relationships with the doctors, but in my view they did treat her differently, will look for this during future observations; (later she agreed that this was probably correct). I noticed the patients are sometimes referred to by their conditions, such as, the section from yesterday, this applied to midwives, midwife practitioners and medical staff. Also think the midwife practitioners have more confidence and perhaps more authority and are authorised to make decisions, they don't seem to worry about it so much. **Theme – decision-making and planning care.**

It was surprising that none of the women we saw objected to my being present when the midwife practitioner assessed them, I think if you look like a health care worker and appear confident you can easily be accepted. The medical staff seemed friendly towards me and seemed to accept that I was always around when they came to see women, without question. Initially the midwives seemed determined to look busy, which was difficult as the unit was quiet. I tried to be very informal and friendly towards them and by the end of the first night they appeared more relaxed about my being there.

Night 2, 21/11/04 Sara

Five midwives on duty: teams - 1 sister and 1 staff midwife, core team - 1 sister and 1 staff midwife, midwifery led - 1 sister, also one health care assistant on duty.

Before she went to bed the middle grade said "I'm going to my room now, I hope you don't disturb me", this was said in a half joking manner. **Theme – relationship with medical staff.**

When I came on duty there was a woman (client a) waiting to be clerked on the ward. There was no information from the junior doctor who was in the Accident and Emergency department. Sara bleeped the middle grade, who informed her the patient had hyperemesis. The woman and her partner were sitting on chairs outside the office, Sara asked the nurses which bed she could use and then settled the woman there, talking to her and her partner. **Theme – relationship with nurses/midwives.** Sara took a detailed history, referring to her crib sheet (information a medical colleague had given her outlining the questions you need to ask and the examinations required). She then talked to them about hyperemesis, the woman's previous pregnancies and home births. Her other babies were born in England and she had problems arranging a home birth there, Sara reassured her about this. After her partner left she confided in us that she was worried because she couldn't do anything and she had to keep working to support him through his training, he was a student nurse, Sara empathised and reassured her that the condition would pass as the pregnancy progressed. Sara put in a venflon and took bloods, but she had to phone the junior doctor to prescribe intravenous fluids and an antiemetic. She decided it was possibly a urinary tract infection, explained this to the woman and requested a urine specimen be sent to the lab. She then informed the staff about the case. There had been no nurse involvement

in the case up to that point; a junior doctor would have had assistance. **Themes – relationship with nurses/midwives, relationship with medical staff, communication with women and decision-making and planning care.**

There were no other calls for the rest of the night. We sat in the office on maternity and chatted with the staff, drinking numerous cups of tea, eating food including a cake the health care assistant had brought in, the atmosphere was relaxed and friendly. During the night Sara helped one of the midwives with an assignment for a course she was undertaking. The midwife practitioners seemed keen to help, I think they felt it would help them become accepted and the midwives appreciated help from what they regarded as more senior midwives. **Theme – relationship with midwives and aspirations to develop services and midwives confidence and practice.**

Sara was bleeped by one of the off duty midwife practitioners who pretended to be a patient with a prolapse, this lightened the mood and I think was done to show support to the midwife practitioner.

The rest of the night we spent chatting with the midwives on the ward, they all seemed friendly and accepting of this new role. Interestingly the midwives do not seem at all offended by the midwife practitioner role, even though she is doing things in her extended role that they would be capable of doing. When they identify a problem and call the midwife practitioner they appear to know what needs to be done but they are happy for her to make the decisions, there does not appear to be any resentment or animosity to this, which is surprising. In my view all midwives should aspire to develop their role, but there was no evidence of that the midwives shared my view. **Theme – relationship with midwives.**

During the handover the midwife practitioner outlined what had been done during the night and what still needed to be done.

Comment

Seemed very obvious that the midwife practitioner was left to clerk the woman without any assistance from staff, she was also expected to put the woman into bed and settle her, she later checked the drugs with the nurses. This does not seem to be a deliberate intention to expect the midwife practitioner to undertake additional duties, they just assume that she is part of their team and should undertake the same work as them, however, this would not be expected from the junior doctor.

Night 3, 22/11/04 Ann

Five midwives on duty: teams - 1 sister and 1 staff midwife, core team - 1 sister and 1 staff midwife, midwifery led - 1, sister, also one health care assistant on duty.

A staff midwife called Ann to see a woman (client a) with abdominal pain, who was 21 weeks pregnant. Ann gathered all the equipment she needed and went to see her, drawing the curtain around her bed. She took a detailed history, while sitting on her bed and chatting in an informal manner, she lowered her voice when discussing personal details of her history, she asked about the woman's family, her sister was

pregnant as well! Ann took bloods and explained about the possibility of infection and advised her to take paracetamol if she had any further pain. The middle grade was on the ward and Ann asked her advice, she suggested taking a high vaginal swab and another blood test and they had a general discussion about the case, the middle grade seemed friendly and keen to help Ann without appearing to be telling her what to do. **Themes – relationship with medical staff, communication with women and decision-making and planning care.**

After this Ann noticed a woman (client b) who had undergone a caesarean section that day and was struggling to breastfeed, she went and had a chat with her and as the midwives were busy she helped the woman to breastfeed her baby. **Theme - communication with women.**

After this we went to Ann's office for a general chat and a cup of tea.

We were later called to room 1 on labour ward by a staff midwife, to see a woman (client c) who had come in with abdominal pain, the midwife had done a cardiotocograph trace but wanted Ann to check the trace and decide what to do. **Theme – relationship with midwives.** Ann was informed that the patient had previously had large babies. The cardiotocograph trace was reactive, but there was a lot of uterine activity and movements. Ann made the decision to advice the woman to stay in, she explained the reasons for this to the woman and her partner and discussed their worries about childcare, her partner agreed that he could cope with the children and Ann eventually convinced her to stay in. **Themes – communication with women and decision-making and planning care.**

As we left the room a midwifery sister asked Ann to check a cardiotocograph tracing of a lady (client d)) who was in room 2, she had attended the labour ward for an injection to be administered, but she was very anxious, due to her history of infertility, so the midwife had put her on the monitor to reassure her. Ann read the casenotes, looked at the cardiotocograph trace and said she could go home. The midwife told the woman she could go before Ann had the chance to see her, A did not seem bothered by this, but the midwife did not even wait for Ann to see her, my feeling was that she knew what should have been done and getting the trace checked was just a formality, but she did not take the initiative and make the decision herself. **Themes – relationship with midwives and decision-making and planning care.**

We were then called to the Accident and Emergency department to see a patient (client e). The casualty doctor had taken bloods for Ann but we did not see a nurse.

Called to the ward by staff midwife to give intravenous antibiotics. Ann had to again gather the equipment and drugs herself and went in to see the woman (client f), A had met her earlier in the night when she had helped her to breastfeed, she explained about the antibiotics and gave the injection, then had a chat with her about breastfeeding. Ann noticed that the patient had difficulty breathing; she was asthmatic and had just used her inhaler. Ann informed the staff about this, the way she gave this information was very casual and she waited for the midwives to say that action had to be taken, they agreed to observe her closely. **Themes – communication with women, relationship with midwives and decision-making and planning care.**

The staff midwife informed her that another lady needed intravenous drugs; Ann again went through the same process, chatting with the woman (client g) while she gave the drugs. There is no reason why the midwives could not give the intravenous drugs, but again they seemed reluctant to take the responsibility. **Themes – communication with women and relationship with midwives.**

During the night Ann was bleeped by the two off duty midwife practitioners who were away on a course, they were staying in a friends house where they had discovered a drum kit; they phoned to play her a tune. Although this may seem trivial I think it was a way of showing solidarity, they knew how difficult things could get and wanted to cheer her up.

We then sat on the ward and chatted with the midwives. **Theme – relationship with midwives.**

Ann became concerned about the woman (client f) who was asthmatic, she was still wheezing, Ann bleeped the junior doctor, who wanted to order medication for Ann to give, but Ann insisted that he needed to examine her. After he saw her he ordered a nebulizer, there was a discussion about the use of the nebulizer and advice was sought from staff on the gynaecology ward. The junior doctor forgot to write up the nebulizer and had to get back up and come to the ward to do it. **Theme – relationship with medical staff.**

While looking in on a woman Ann noticed a baby wheezing, she told the staff midwife looking after her who said "it's just wind". Ann chatted in such a way that the midwife thought it was her idea to call the paediatrician. Comment from Ann " they all have more experience than me but...." The baby was seen and a more senior doctor was called and antibiotics were prescribed. Ann then had another discussion with the midwife about the mother, Ann said "shall we do a high vaginal swab in the morning" the midwife replied, "I've done a cord swab", Ann "Yeah but she spiked a temp (high temperature) earlier didn't she", after this discussion it was agreed a high vaginal swab would be done. **Themes – relationship with midwives and decision-making and planning care.**

Just as this episode was ending a midwifery sister asked Ann to check a cardiotocograph trace as she could hear ectopic beats (client h). Ann advised that it was ok but that they should note it in the casenotes as they may need to scan the baby after delivery. She said: "I'm not an expert by any means but I have seen a few and that is what they normally do", she seemed very keen not to make experienced midwives feel uncomfortable and to ensure their confidence was maintained. The midwife seemed grateful for the advice. **Themes – relationship with midwives, Aspirations to develop services and midwives confidence and practice and decision-making and planning care.**

Ann received a phone call from the labour ward, a woman (client I) was being transferred over from the Birth Centre, with failure to progress in the second stage. When she arrived the middle grade, the practitioner and four of the midwives were waiting on labour ward. She was put into room 1 and put on a cardiotocograph monitor, her observations were checked and she was given entonox. Some fetal heart rate decelerations were noted and the middle grade performed a vaginal examination,

she wasn't sure of the presentation, but was concerned that the contractions were not strong enough. Ann put a venflon in and an infusion of syntocinon was commenced and the woman was encouraged to push. While this was going on another midwife put an oxygen mask on the woman's face to try and increase the baby's oxygen levels. At this stage the small room was full, the woman's partner and mother were there along with three midwives the middle grade, the practitioner and me. Staff were looking to see what needed to be done and doing it, other than the midwife who was speaking to the woman there wasn't a great deal of talk, but the woman still looked overwhelmed by everything that was happening to her. After a few minutes the middle grade checked the vaginal examination, asked the midwife to check it and they decided it was a possible brow or face presentation. Ann stood back and left the midwife to be in charge of the case. A caesarean section was needed and everyone worked together to prepare her. Ann took her consent and then we went into theatre to 'scrub'. The middle grade and Ann stood waiting while the anaesthetist put the spinal anaesthetic in. The operation went quickly and Ann assisted. The atmosphere in theatre was light and friendly, the doctor seemed confident in Ann's ability to assist. It felt very strange to watch the operation all the way through and not have a job to do. **Theme – relationship with midwives.**

When Ann had finished we had a chat with the midwives before the shift ended. **Theme – relationship with midwives.**

I left before the end of Ann's shift as she was working extra to make up her hours.

Comment

Ann appeared efficient, calm and reassuring when speaking to women, she spoke to them like a midwife, taking their social issues on board as well as their physical problems. The midwives seemed happy about calling her; they seemed to know what to do but were happy to call Ann to make the decisions. There did not appear to be any resentment about this, but the midwives could be blasé about the management of care after they had called a midwife practitioner or doctor. **Theme – relationship with midwives.**

Ann stated that, "It is important the way you ask midwives to do things, sometimes you have to go in a roundabout way to get them to do what you want them to do, as it is important to keep them on side so they work with you, if they realise that you have made a good decision once they will accept your decisions in future". She had identified a problem with a baby that the midwife had missed, the midwife did not initially see that there was a problem, it turned out to be an infection and both the junior and middle grade treated the baby. **Theme – relationship with midwives.**

Again the midwife practitioners inability to prescribe and deal with medical conditions caused work for medical staff. Interestingly the handover report from the doctor in the Accident and Emergency department was very good, much better than the obstetric reports. Comment from Ann "This is where the problem is you see when you have got to deal with something that is not just obstetrics, we are not medically trained so we don't know how to deal with these problems and if the junior doctor wasn't here I would have to wake the middle grade and they wouldn't be happy with that". My view is that this could be a potential problem, because although they can do the basics in obstetrics and gynaecology, if there are any other problems they need

medical assistance, I do not now how this could be remedied. **Theme – relationship with medical staff.**

During informal chats Ann stated, "When you do this job you have to think more, to stretch yourself and think of all the possibilities". Ann stated that she still feels nervous about some of the decisions she has to make, but she feels that gaining more experience will improve things. **Theme - desire to further develop their knowledge and skills.**

A commented that she feels all midwives are capable of doing what she does, but they are happy to stay within the parameters of what has always been done and do not move forward, perhaps because of the constraints of their role, she said, "All of those down there (midwives) could do what I do, but they don't, they do what's expected, it has always been that way". In my view, perhaps they don't feel they have this autonomy and that they may get into 'trouble' if they exceed their role, perhaps in the past this would have been the case. **Theme – aspirations to develop services and midwives confidence and practice.**

It is very apparent that a noticeable difference between the role of the midwife and the midwife practitioner is the way the midwife practitioners move from one woman to another, this limits the relationship building, which is a part of the midwives' role. However, the midwife practitioners compensate for this in the way they communicate with women, taking their emotional and social needs into consideration and speaking in a way the women can relate to. **Theme – communication with women.**

When the woman was transferred from the birth centre A stood back and allowed the midwife to remain the midwife in charge. I found it quite difficult to stand back and probably became more involved than Ann, comforting the woman and assisting the midwife. **Theme – relationship with midwives.**

Night 4, 23/11/04 Ann

Five midwives on duty: teams - 2, staff midwives, core team - 2, staff midwives, Midwifery Led - 1, sister, also one health care assistant on duty.

When I arrived Ann was already on the labour ward discussing a woman (client a) who had been admitted with query spontaneous rupture of membranes, shortness of breath and raised pulse rate. Ann had already done a speculum examination and an ECG. The middle grade came on duty and said she would go and change and review the woman. Ann was then bleeped to attend the Accident and Emergency department to see a patient. This again emphasised the need to move quickly from one woman to another, without any time to get to know them. **Theme – relationship with women.**

While she was writing out the pathology forms Ann said "you are always comparing yourself to them (the junior doctors), you think, what would they do, am I doing what they would have done"? Ann told me about the advice she was given by one of the junior doctors, which she had been told as a medical student: "Look at them, are they going to die in the next hour, no? Are they going to die in the next 24 hours, no? Then

relax and don't get too worked up about it". **Theme – relationship with medical staff.**

Ann was bleeped to attend the ward to see a woman (client c) who was 36 weeks pregnant with pregnancy induced hypertension and chest tightness. Ann made her usual introductions, explaining that she was a midwife practitioner and not a doctor, this never seemed to bother women who just accepted her as one of their carers. Ann took her history and considered the signs and symptoms. The woman's blood pressure was raised, there was protein ++ and ketones +++ in her urine, she had a frontal headache and her haemoglobin level was down. Ann. checked her stats, her reflexes and her ECG, Ann explained to the woman that she was still learning how to do this so asked her to be patient with her, the woman laughed. Ann always sits down when talking to patients and tries to put herself on their level. On this occasion she was chaperoned and assisted by a midwife. Ann explained to the woman that she would speak to the middle grade about her case, who would come to see her. The middle grade reviewed her and ordered labetalol and 2 hourly blood pressure checks. At the nurses station the middle grade, practitioner and midwife had a humorous if cruel discussion about tattoos and how they tend to make you label women. **Themes – communication with women, relationship with midwives and relationship with medical staff.**

The unit then became quiet and one of the midwives did Tarot card readings for us all, complete with black cloth and a cot sheet tied around her head to give the full effect, she was quite accurate when doing my reading! This passed a few hours. **Theme – relationship with midwives.**

Called to labour ward to see a woman (client d) who was 34+ weeks pregnant with a history of abdominal pain and discharge. Ann took her history and examined her, it appeared she had an infection, Ann took a high vaginal swab and did a vaginal examination to confirm that she was not in labour. Ann advised her to stay in overnight as she was having irregular pains and might go into labour and would then have to come back in. Ann spoke to the woman and her family in a way they could relate to. **Themes – communication with women and decision-making and planning care.**

We were called to the Accident and Emergency department to see a woman (client e)

We spent the rest of the night chatting with the midwives on the ward. **Theme – relationship with midwives.** A lot of the time the midwife practitioners are just waiting for the bleep to go off.

Ann's handover consists of what has happened during the night, any problems and any work outstanding.

Comments

A. told me that she still questions what she is doing and the decisions she makes. Although she appears confident she said that, there is a constant dialogue going on in her head, when she is seeing patients. She feels that she has learnt a great deal and has been on a steep learning curve since taking up post, but still feels she still needs more

time before she will feel confident. **Theme - desire to further develop their knowledge and skills.**

She says she is surprised by how staff accept her and how senior midwives ask for and accept her advice, she wonders why midwives limit themselves in their practice. Perhaps it is to do with the issue of assimilation discussed in phase 1. The midwives are able to keep themselves up to date with ongoing training, but do not seem keen to develop their role, perhaps nobody wants to 'rock the boat', in case it will be expected of all midwives, even those who don't want to change. **Theme – relationship with midwives.**

It was noticeable that the midwife practitioners are able to move from one client to another, they seem to enjoy the variety, rather that finding it stressful. Again they did not let this affect the way they communicated with women. **Theme – relationship with women.**

Thoughts after the first week

In my view at this stage the main aims of the MP's are:

- To diagnose problems.
- To develop plans of care to remedy the problems.
- To provide appropriate and safe clinical care for women.
- To build trust and develop a rapport with the women they care for.
- To help develop maternity services and midwives confidence in their own abilities.

The overriding aim is to support women who develop complications and provide them with safe clinical care, which is delivered by an effective team.

All of the midwife practitioners stated that their goals were to further develop their knowledge and skills and also to 'fit-in' and be accepted by other members of staff.

The advantages of the midwife practitioners role is that they are able to develop a rapport with women quickly and are able to consider their emotional and social needs as well as their physical needs. They also discuss health issues and provide advice during their conversations with women. They may also provide the link between midwifery and medical staff, which may further improve and develop multidisciplinary working. The midwife practitioners also undertake midwifery duties, which assists the midwives.

The midwives appeared to be keen to refer women to the midwife practitioners, but often acted as if they were not worried about the woman's condition after the referral had been made. As they no longer had responsibility for the management of care it was easy for them to take this view, but the midwife practitioners still had to be cautious as they were accountable for the decisions they made.

The disadvantage of these posts is that they are likely to increase the workload of middle grade doctors. Midwife practitioners are unable to prescribe and they are not

trained to deal with medical or surgical problems so they have to refer more frequently to middle grades than junior doctors who have a background in general medicine and are able to prescribe.

Week 2, Night 5, 2/12/04 Lyn

There were five midwives on duty: core team - 3 staff midwives, teams - 1 staff midwife, midwifery led - I midwifery sister and 1 health care assistant on duty.

I accompanied Lyn to labour ward to receive handover from the junior doctor, who arrived and said it's ok here and then asked Lyn what was happening on labour ward, a midwife had already told Lyn what was happening when we arrived on labour ward, so she knew.

Lyn knocked on the door of room 4 and asked the midwife about her case and about her weekend away in Stockholm to attend a wedding. There followed a pleasant conversation about the recent trip and the client, whose condition was fine. **Theme – relationship with midwives.**

We then went to the wards to check that everything was ok.

At 23.00 hours Lyn was called to ward 21 to see a client (client a). On our way we passed the junior doctor in the corridor. Lyn asked (name of doctor) if she knew anything about the woman, she didn't but even though Lyn told her to go to bed she accompanied us to the ward. The staff midwife on the ward told us about the woman, she said that the woman had a poor urinary output and had some protein in her urine. Lyn read the case notes but the junior doctor went straight in to see the woman. I felt there was a degree of competition between Lyn and the junior doctor, Lyn was aware of this and was slightly amused, but also irritated by it. After reading the casenotes Lyn decided to repeat the blood tests, but when we went to the bedside the junior doctor was suggesting catheterisation. Lyn asked the woman what had been happening and about her history, the woman was very anxious about the catheterisation and Lyn reassured her (although she did not think that this was the best course of action). Lyn did the bloods and the junior doctor did the catheterisation.

The junior doctor bleeped the middle grade to inform her of the case and both she and Lyn wrote in the casenotes. **Theme – relationship with medical staff.**

In my view neither of these actions were inappropriate but there did seem to be two completely different consultations going on simultaneously. After the woman had been seen, the staff midwife made us all a cup of tea. Interestingly both Lyn and the junior doctor admitted that neither of them was sure what the problem was. The junior doctor obviously felt that she was the most appropriate person to see the patient and seemed to have the view that her position was being usurped. Perhaps this had more to do with the fact that she was bored!! The other doctors we worked with, male and female, did not demonstrate this keenness to get involved with caring for women

After this the night was very quiet, we chatted for a while with the staff on ward 21, then went and had a chat with the staff on labour ward. **Theme – relationship with midwives.**

Lyn's handover consists of what has happened during the night, any problems and any work outstanding.

Comments

When Lyn told the junior doctor about the woman, the junior doctor seemed very keen not to be usurped in the management of the case, she read the notes first, saw the woman first, she contacted the middle grade rather than leaving it for Lyn to do, even though Lyn did say that she was ok to see the woman and suggested she went to bed. The junior doctor seemed very pleasant and friendly, but it seemed strange that she was so keen on doing the work at that time of night, she even catheterised the woman herself. Usually there is added pressure on the midwives because although the doctors are now working shifts rather than on-calls they still have the view that it should be treated as an on-call and that they should be able to sleep. This causes some conflict as the midwife practitioners have to stay awake all night. Lyn could have overruled the doctor, if she felt her care was not safe, but this was not the case, they just had a different approach. **Theme – relationship with medical staff.**

Night 6, 3/12/04 Sara

There were five midwives on duty: core team - 3 staff midwives, teams - 1 staff midwife, midwifery led - I midwifery sister and 1 health care assistant on duty.

The handover consisted of the junior doctor saying there was nothing to report.

At 21.50 hours we were called to the labour ward, the staff midwife informed Sara that a woman (client a) she was caring for had fetal heart rate decelerations showing on the cardiotocograph, these were now shallow decelerations. The midwife stated that it was ok if you held the transducer in place, suggesting that the problem was loss of contact. Sara called the middle grade, who came and said it was ok as the woman would deliver soon, the midwife then stayed and held the transducer in place. It is my view that midwives can sometimes be laid-back about cases, after they have called someone, perhaps they feel they can be brave and take chances because it is no longer their responsibility. I can relate to this, but it is not a sound way to proceed. The midwife practitioners and medical staff do not have the luxury of handing over the responsibility, perhaps this is one of the main differences and is something which will improve the image and status of midwives. The midwife practitioners seem very skilled at ensuring the correct action is taken without offending the midwives, their communication skills are well used when facing this issue. **Theme – relationship with midwives.**

After this Sara was 'minding' the labour ward (the midwife was with the woman, while the other staff were on the ward, this seemed to be usual practice). **Theme – relationship with midwives.** Sara was bleeped by a doctor from Primecare (the out of hours GP on-call service), he stated that he was sending in a patient (client b) who

was seven weeks pregnant and was bleeding per vagina. Sara said " you will send in a referral letter with her, yes" to which the doctor replied "no I have triaged her over the phone (this is inappropriate and it could be said is impossible,as you cannot assess a patients condition over the phone) as I'm up in (name of place some distance away from the area covered). Sara pointed out that he should have assessed her before arranging admission, but the doctor was adamant that this would not be necessary. I asked Sara if this was usual practice and she said it was.

We attended the ward to admit this patient. When she arrived Sara introduced herself, explained about her role and took a detailed history. After gaining the woman's consent she did a speculum examination and took swabs for routine HVS and clamidia, a vaginal examination revealed right-sided abdominal tenderness. Sara took bloods and ordered a scan for the following day. Sara explained to the woman why she had to stay in and reassured her, she made detailed records in the casenotes and informed the staff of what the problem was and what plan of care was required. **Themes – decision-making and planning care and communication with women.**

24.20 hours Sara called to labour ward by midwifery sister, a client (client c) who had a previous caesarean section was in labour, her cervix was four centimetres dilated and she was complaining of scar tenderness. Sara read the casenotes and chatted to the woman, Sara put a venflon in, in case it was needed later. My impression was that the midwife felt we should be helping out as the labour ward was becoming busy, but we did not assist as we had to be available to respond to the next call. **Themes – decision-making and planning care and relationship with midwives.**

At 02.50 hours we attended labour ward, as a client (client d) was being brought in by her midwife, she had been booked for a home birth but was now bleeding per vagina. Sara put a venflon in and stood back, at this time there were lots of midwives in and out of the room and the paediatrician was present. The middle grade did a vaginal examination and decided that a ventouse delivery was required, she undertook the ventouse and a huge baby was born in a good condition. Sara decided to leave as there were already too many people in the room and the midwife who had brought her in looked as traumatised as the woman and her partner. Sara told me later that the midwives don't like it if you take over, so you do what's needed then take a back seat, as it is their case not yours. Again I found it difficult to stand back and not intervene. **Theme – relationship with midwives.**

After this the midwifery sister caring for the woman with scar tenderness (client c) asked Sara if she should do an artificial rupture of membranes as there had been little progress, Sara said yes do it (the midwife must have known what to do but again preferred to pass the responsibility for decision making). The woman progressed from her cervix being four centimetres dilated to full dilatation in half an hour. The fetal heart rate dipped down and stayed down. The middle grade was called and did a ventouse delivery, the paediatrician was present and again the room became very busy, Sara positioned herself out of the way. The baby was born in a very poor condition. The paed and the middle grade resuscitated the baby and Sara called for the middle grade paediatrician, did the cord ph, informed the Special Care Baby Unit and stayed in the background. The baby was eventually transferred to the Special Care Baby Unit. It is questionable whether the junior doctor would have done this and Sara therefore provided more assistance to the midwives than a doctor would have done.

This case shocked all those present; but Sara maintained a calm presence. Again she did not take over any of the midwife's jobs. I stayed in the room and reassured the woman. **Theme – relationship with midwives.**

Somebody (not sure who) made tea for everyone and we all gratefully took time to recover, but the bleep went off again and we had to attend the Accident and Emergency department to see a patient (client e). Although it seemed more like a surgical case the staff still wanted Sara to come and assess her, as they knew they would get a quicker response from Sara. While we waited for the blood results the staff made us a cup of tea and we chatted about their problems and they entertained us with tales of what it is like to be an Accident and Emergency nurse. **Theme – decision-making and planning care.**

While we were there the bleep went again for another case of fetal distress on the labour ward, we ran back up, the middle grade and paediatrician were already there, it was like a repeat of the case earlier and everyone was smiling but obviously very tense. On this occasion the woman (client f) progressed quickly and we just stood there in readiness in case any assistance was needed, again Sara stayed in the background and did not try to take over. The baby delivered normally and in good condition, it was hard to decide who out of all of us was more relieved. **Theme - relationship with midwives.**

We walked back very slowly to the Accident and Emergency department, where Sara finally accepted that the bloods would not be done that night, so we would have to admit the woman (client e) to the gynaecology ward. Sara wrote in the notes, informed the woman and phoned the ward to let them know that she was sending up a patient.

We spent the remainder of the night chatting with the midwives on labour ward discussing the events of the night. **Theme – relationship with midwives.**

I left before the end of Sara's shift as she was working extra to make up her hours, (the midwife practitioners work day and night shifts and they sometimes work long night shifts to ensure they have worked their contracted hours).

Comment

The midwife practitioners stand back, they do what needs to be done but they don't try to take over from the midwife. Sara during a ventouse delivery "there's too many people in here, I'll wait outside". The midwives like to be the ones who are seen as being in charge of their cases and jealously guard this, even after a course of action has been decided and they are no longer the ones with the ultimate responsibility for the case – see phase 1 jealousy, in relation to delegating their duties. The midwife practitioners are keen that the midwives retain this position. As an experienced midwife I found it quite difficult not to take over and on occasion I became more involved than I had planned to.

The midwife practitioners also sell decisions as if they were the midwives idea. During week one Ann stated to a midwife, "that babies breathing sounds a bit off", the

midwife then realised that it needed to be seen by a paediatrician. They also encourage midwives to say what they think should be done. This conversation took place during a phone call with a staff midwife regarding whether she should give a woman pethidine when she was not in established labour, but was very distressed during the middle of the night. Sara during night 3 "what do you think we should give", the midwife replied, "I think she could do with 50mgs of pethidine", Sara "yeah I think that would be a good idea, give her that and see if she settles". This was a simple decision and the midwife just needed a bit of encouragement that she was doing the right thing. **Theme – relationship with midwives.**

Night 7, 4/12/04 Ann

There were four midwives on duty when I arrived, the fifth was working from 24.00 hours to cover sickness, before this Ann had agreed to assist them: core team - 2 staff midwives until 24.00 hours then 3, teams - 1 staff midwife and 1 midwifery sister, midwifery led - 0 and 1 health care assistant on duty.

When I arrived Ann was on the ward chatting with the junior doctor, she was due to finish her contract soon and return to home, she told us all about her family there and how keen she was to return. Before I had arrived one of the off-duty middle grades had called over to the ward, he had been complaining to Ann and the junior doctor about a throat infection he had been suffering from and generally moaning about his state of health. **Theme – relationship with medical staff.**

At 22.20 hours Ann was called to labour ward to see a woman (client a) who was term with a possible spontaneous rupture of membranes. After discussing the case with the staff midwife, Ann went and saw the woman, she ascertained that she was worried because she had a previous ventouse delivery and was afraid she would need one again. Ann reassured her and explained what she would do, after gaining consent she did a speculum and a vaginal examination, some liquor was draining and the amniostick was positive. Ann advised her to stay in but the woman did not want to so she went home. Ann advised her to attend the day unit the following day if she had not gone into labour. **Themes – communication with women and decision-making and planning care.**

Called to labour ward by midwifery sister to assess a woman (client b) who had a possible spontaneous rupture of membranes, she had arrived by ambulance unaccompanied and needed a lot of support. The midwife had prepared the trolley and the woman for a speculum examination. Ann discussed the case with the midwife and read the casenotes. Ann went into the room and talked to the woman in a way she could understand. Ann gained consent and undertook a speculum examination took a vaginal swab for clamidia, she palpated her abdomen and decided that the problem was probably a thrush infection. She advised the woman to stay in (she had no transport to go home) and explained that a doctor would prescribe the necessary medication in the morning. Ann informed the midwife who said, "fine I'll take her over and come back and do the notes and I'll make the bed when I come back", Ann picking up on the hint did the bed, it was a trade off, the midwife had helped her so she helped the midwife. However, a junior doctor would not have been expected to do this as they would see bed making to be to menial a task for them. **Themes –**

communication with women, relationship with midwives and decision-making and planning care.

Ann said during a conversation later, "there was nothing I did tonight that they couldn't have done, they just need the confidence and encouragement to do it". We spent the rest of the night chatting with the midwives. Ann helped one of the midwives with work she was doing for a course. **Themes – relationship with midwives and aspirations to develop services and midwives confidence and practice.**

Comment

The relationship with the medical staff surprised me, I had worked with these doctors for a number of months and realised how little I knew about them. I felt that the midwife practitioners had more in common with them as they experienced the same problems and had the same responsibilities. **Theme – relationship with medical staff.**

A seemed particularly keen to help the midwife with her course work, I think this was both to help develop the midwife's knowledge, but also to help her become accepted by the staff. **Themes – relationship with midwives and aspirations to develop services and midwives confidence and practice.**

Night 8, 5/12/04 Ann

Five midwives on duty: teams - 1 sister and 1 staff midwife, core team - 1 sister and 1 staff midwife, midwifery led - 1 sister, also one health care assistant on duty.

We were called to the Accident and Emergency department to see a woman (client a). Ann arrived and spoke to the nurse on duty, the department was full and there were 17 patients waiting for beds, a patient who had just had a cardiac arrest was still in the resuscitation room as there was no bed elsewhere for him and the corridor was lined with patients on ambulance trolleys, with paramedics in attendance. The mood was now very different than on previous occasions when we had attended, the staff appeared stressed and there was a sense of urgency that something had to be done. With so many ambulances stuck there, it may have been difficult for other emergency cases to be brought in or for the patients already there to be cared for safely. However, there was no obvious solution, although staff expressed the view that the hospital should be closed. I found this quite strange, as this is a problem I am regularly phoned about when I am on-call for the Trust, however, I was shocked by the reality of seeing the situation for myself. Our client was on one of the ambulance trolleys, even though she had received entonox and morphine.

Called to ward to assess a woman (client b) who was admitted with abdominal pain, after a fight broke out close to her in a club, her partner accompanied her and both had been drinking. Ann explained patiently what she was going to do and gained her consent. Ann did an abdominal examination and did a speculum examination, taking a vaginal swab for clamydia. Ann ordered a mid-stream urine specimen to be collected and did a verbal order for antibiotics, which she said could be written up in the

morning. When we went back later to check on the woman she was sleeping. **Themes – communication with women and decision-making and planning care.**

Called to labour ward to see the woman (client c, but client a of the previous night) who had been admitted with a possible spontaneous rupture of membranes the previous night. She was now in labour but had a fetal tackycardia and a raised temperature. Ann checked the monitor, discussed the case with the junior doctor and accepted a verbal order for intravenous antibiotics and paracetamol. Ann gave the antibiotics and reassured the woman, her partner and her other relatives who were also present. Ann explained some detail of the normal care pathway to the midwife, they had a general discussion about this and the midwife seemed happy with the advice and action taken. **Themes – communication with women, relationship with midwives, relationship with medical staff and aspirations to develop services and midwives confidence and practice.**

We spent the rest of the night chatting with the midwives on the ward, one of the midwives had brought in home made cakes and was busy decorating the Christmas tree and sorting through the decorations. **Theme – relationship with midwives.**

Comments

I was shocked by the situation in the Accident and Emergency department and to see first hand how this compromises care and causes stress for everyone involved.

Ann managed the woman who had been involved in the fight very well and managed to get her to agree to the assessment and treatment in spite of the fact that both she and her partner had appeared to be under the influence of alcohol. **Theme – communication with women.**

Overview of participant observation

During the period of participant observation the following themes emerged:

- Communication with women - attempts to meet emotional and social needs, conversations not just gaining and imparting information,
- Relationship with midwives - the midwife practitioners keenness to be accepted by the midwives, selling ideas as if the midwives had made them, assistance taken for granted by midwives, midwives deferring to the midwife practitioners, ensuring midwives still feel they are in charge of the case.
- Relationship with medical staff (equality with, self preservation and boundaries) - lack of prescribing rights and non-obstetric knowledge, concerns about increased workload, improved relationship.
- Decision-making and planning care
- Aspirations to develop services and midwives confidence and practice.

Sub themes will be developed as analysis proceeds.

I found that I experienced some dilemmas during the participant observation. The view of the medical staff, that they were on-call and should be allowed to sleep, was difficult to accept when I was aware that they were being paid to work a shift. I also found it hard to keep quiet when the midwife practitioners were prompting the midwives to identify problems, but this is probably just a different style of managing a situation.

I felt that the midwife practitioners ask the direct questions and they make the decisions; it seems a strange situation that a midwife calls somebody else to do what she is capable of and defers to the midwife practitioner as the ultimate decision maker. I also think the midwife practitioners have more confidence and are authorised to make decisions, they don't seem to worry about it so much.

The midwife practitioners speak to the women in the same way as the midwives speak to them, it is a general conversation between people on the same level, rather than just as a clinician making a diagnosis and ordering the management of care, they seem to relate much better to women. However, I did notice that women are sometimes referred to by their conditions, such as, the section from yesterday. Their relationship with the medical staff is interesting as doctors seem to accept the midwife practitioner as one of their own and speak to them on a different level to the way they speak to the midwives, they tend to have more personal conversations and relate to each other much better. Their relationships with the midwives generally seem very good, they seem friendly and approachable and prepared to assist the midwives, however, I think this is sometimes taken for granted on occasion. The midwife practitioners stand back, they do what needs to be done, but they don't try to take over from the midwife. The midwives like to be the ones in charge of their cases and jealously guard this (see phase 1 jealousy, delegation of duties). The midwife practitioners are keen to ensure that the midwives retain this position. They also sell decisions as if they were the midwives idea.

The midwife practitioners also seem to take more ownership of the unit, wanting to improve services and the environment, whereas junior doctors are just passing through and tend not to have that level of commitment to the unit and midwives tend to feel that this is somebody else's job and often resent changes (see phase 1, influencing factors). Midwife practitioners also seemed keen to help midwives develop more confidence in their abilities.

When traditional midwives identify problems they have to call for assistance and take a passive role, although they can identify problems and seem to know what action should be taken. At this stage they abdicate responsibility and defer to the midwife practitioner or obstetrician to manage the care. Traditional midwives take on a role similar to that of nurses, by supporting and carrying out the instructions of midwife practitioners or obstetricians, perhaps this is why midwives are often described as nurses (see phase 1, perceptions of midwives). Perhaps these issues may be influencing factors in the low morale noted amongst midwives and the difficulties experienced in retaining them within the profession.

Functions of traditional midwives:

- To provide appropriate and safe clinical care for women, identifying deviations from the norm and calling for assistance.
- To be supporting and caring, taking control of the situation when necessary.
- To build trust and develop supportive relationships.
- To provide support for partners.

Functions of midwife practitioners:

- To ensure appropriate and safe clinical care for women, which is delivered by an effective team.
- To diagnose problems.
- To develop plans of care to remedy the problems.
- To build trust and develop a rapport with the women they care for.
- To help develop maternity services and midwives confidence in their own abilities.

The overriding aim of midwife practitioners is to support women who develop complications and ensure the provision of safe clinical care, which is delivered by an effective team. The differences between the roles are: That traditional midwives identify problems and call for assistance, whereas midwife practitioners diagnose problems and develop plans of care for dealing with these. Midwife practitioners are unable to build relationships with women and their partners, as the amount of time they spend with them is limited, although, they aim to develop a rapport with them. They also see their role as being able to develop services and midwives confidence in their abilities. All of the midwife practitioners stated that their personal goals were to further develop their knowledge and skills and also to 'fit-in' and be accepted by other members of staff.

The disadvantage of these posts is that they are likely to increase the workload of middle grade doctors. Midwife practitioners are unable to prescribe and they are not trained to deal with non-obstetrical problems, so they have to refer more frequently to middle grades than junior doctors would have to. The frustration of middle grades was apparent when they were called during the night to deal with problems.

The advantages of the midwife practitioner role are that they are able to develop a rapport with women quickly and are able to consider their emotional and social needs as well as their physical needs. They also discuss health issues and provide advice during their conversations with women. They may also provide the link between midwifery and medical staff, which may further improve and develop multidisciplinary working. The midwife practitioners also undertake traditional midwifery duties, which assists the midwives. But it is the acceptance of the additional responsibilities of decision-making and planning of care when problems arise, which makes the biggest difference and which is likely to improve the provision of midwifery care and the status of midwives.

I was aware that the way I saw and interpreted events may have differed from the way the midwife practitioners saw things. In an effort to check the accuracy of my findings the midwife practitioners read this overview and agreed with my interpretation of the events witnessed during the period of participant observation.

APPENDIX – 10

Table illustrating the four stages in the process of identifying themes and sub-categories for Phase One.

Stage 1 Analysis by hand		Stage 2 Analysis using NVivo		Stage 3 Merging stages 1 & 2		Stage 4 Compression of themes	
Themes	**Sub-categories**	**Themes**	**Sub-categories**	**Themes**	**Sub-categories**	**Themes**	**Sub-categories**
Essential functions	Relationship building Building trust Taking control Giving guidance Confidence in ability Continuity Support for partner	**Essential midwifery functions**	Relationship building Taking control Generating confidence Continuity of carer Support for partners Holistic care Ensuring safety Record keeping Supporting and caring	**Midwifery functions in the provision of intrapartum care**	Ensuring safety Taking control Confidence in ability Support for partners Relationship building	**Midwives' perceptions of the essential midwifery functions in the intrapartum period**	Ensuring the safety of mother and baby Building a supportive relationship with women Providing support for birth partners
Delegation of duties	Territorial attitudes Jealousy Staffing necessity Getting the balance right	**Delegation of midwifery duties**	Territorial attitude about role Jealously guarding role Staffing needs Getting the balance right when delegating	**Relinquishing aspects of role**	Losing the essence of role Prestige of midwife practitioners role Balancing need against safety Territorial attitudes Jealousy of other professionals	**Relinquishing aspects of the role**	Jealousy and territorial attitudes The consequence of staff shortages The impact of midwife practitioner roles
Perceptions about midwives	Invisibility Stroppy/difficult Demonstrating worth Elitist Misrepresented Improving image	**Others perceptions about midwives**	Invisibility of role Image of being difficult Demonstrating worth Elitist nurses Misrepresented as specialist nurses Improvement of image	**Perceptions**	Stroppy and difficult to deal with Invisible in eyes of the public Need to demonstrate worth	**Midwives' views of how they are perceived by others**	Difficult and elitist Invisible and misrepresented Demonstrating worth
Influencing factors on role	Politics Training Cyclical changes Medical dominance	**Factors influencing role**	Political influence Midwifery training Cyclical changes Medical dominance Consumer pressure	**Organisational climate**	Staffing issues Assimilation Being controlled Low morale Medical dominance Cyclical changes	**The experience of midwives working in the NHS**	Pressure to conform. Problems with midwifery training. Cyclical changes within the NHS.
Midwife Practitioners	Attitudes Approval Expertise Lack of understanding	**Midwife Practitioners**	Losing the essence of midwifery Approval of posts Unjustified prestige Lack of understanding Exploitation				
Organisational climate	Assimilation Being controlled Constant changes Staffing levels Morale	**Organisational climate**	Assimilation into the system Control Changes Staffing shortages Morale Influence of finance				

APPENDIX - 11

Table illustrating the four stages in the process of identifying themes and sub-categories for Phase Two.

Stage 1 Analysis by hand		Stage 2 Analysis using NVivo		Stage 3 Merging stages 1 & 2		Stage 4 Compression of themes	
Themes	**Sub-categories**	**Themes**	**Sub-categories**	**Themes**	**Sub-categories**	**Themes**	**Sub-categories**
Relationship with women	Communicating as midwives not doctors Meeting women's needs	**Communication with women**	Rapport Holistic care	**Communication with women**	Establishing rapport with women Meeting social and emotional needs of women	**Interaction with women**	Developing a rapport with women and their birth partners Meeting women's social and emotional needs
Relationship with midwives	Need for acceptance Deferring to midwife practitioners Midwives maintaining control Midwives expectations of midwife practitioners Part of the team	**Relationship with midwives**	Need for acceptance by midwives Midwives deferring to midwife practitioners Midwives need to maintain control over their cases Need to be accepted as team member	**Relationship with midwives**	Accepted as part of midwifery team Midwives expectations of midwife practitioners Midwives desire to maintain control over the provision of care	**Affiliation with other midwives**	Striving to belong to the midwifery team Midwives' expectations of midwife practitioners Ensuring midwives retain control over care
Relationship with doctors	Equity with doctors Prescribing Non-obstetric knowledge Increased workload Improved relationship	**Relationship with doctors**	Equity with doctors Increased workload Improved relationship	**Relationship with medical staff**	Limitations of midwife practitioners' role Improved relationship and equity with obstetricians	**Integration with obstetricians**	Constraints of midwife practitioners' role Equity with obstetricians
Decision-making and planning care	Changes to midwife practitioners decision-making Reluctance of midwives to take responsibility for decision-making	**Decision-making**	Need to develop knowledge and analytical skills Why midwives defer to doctors and midwife practitioners	**Development of services and practice**	Further development of knowledge and practice of midwife practitioners Encouraging midwives to develop their practice	**Developing practice**	Developing midwife practitioners' practice Encouraging the development of midwifery practice
Developing service and practice	Midwife practitioners' practice Midwifery practice and services	**Developing practice**	Further development of midwife practitioners role Potential to influence development of midwifery practice				

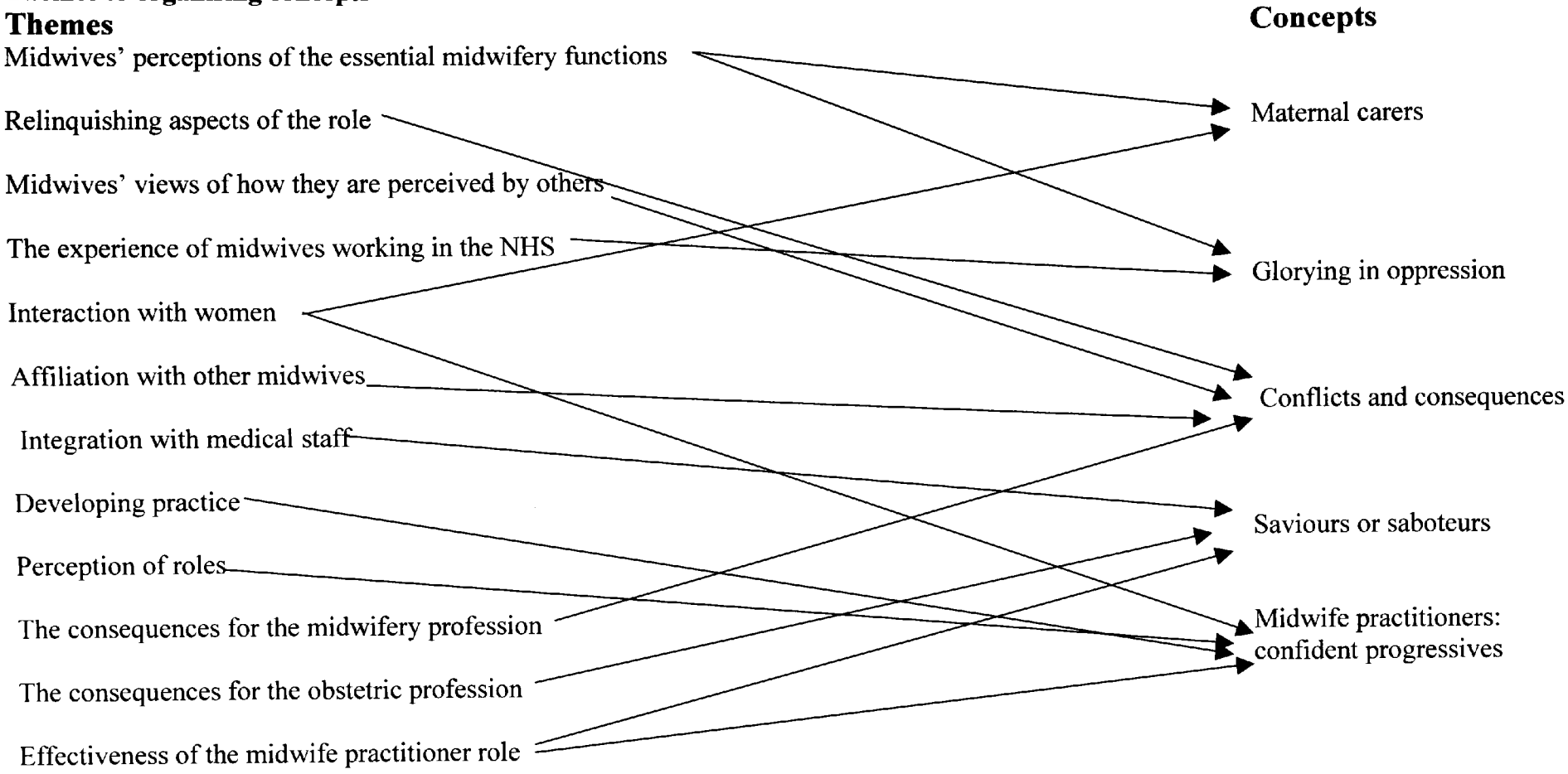
APPENDIX - 12

Table illustrating the four stages in the process of identifying themes and sub-categories Phase Three.

Stage 1 Analysis by hand		Stage 2 Analysis using NVivo		Stage 3 Merging stages 1 & 2		Stage 4 Compression of themes	
Themes	**Sub-categories**	**Themes**	**Sub-categories**	**Themes**	**Sub-categories**	**Themes**	**Sub-categories**
Training	Lack of experience for junior doctors. Preparation for midwife practitioner role.	**Impact on midwifery**	Support for midwives. Increased expectations. Depletion of staffing levels. Development of midwives. Career progression. Understanding of the midwives' role.	**Perception of roles.**	Perceptions about midwives. Perceptions about obstetricians. Perceptions about midwife practitioner roles.	**Perception of roles.**	Perceptions about midwives. Perceptions about obstetricians. Perceptions about midwife practitioners.
Communication	Improved communication. Better information giving. Displaying confidence.	**Impact on obstetrics**	Junior doctors' experience. Effect on workload. Necessary development. Midwives and high-risk care. Understanding of the obstetricians' role. Hostility to midwife practitioner role.	**The consequences for midwives.**	Support for midwives. Depletion of midwifery staffing levels. Development of midwives. Increased expectations of midwives.	**The consequences for the midwives**	Support for midwives. Depletion of midwifery staffing levels. Future development of the midwives. Increased expectations of midwives.
Staffing	Career progression. Depleting midwifery staffing levels.	**Impact on care provision**	Acceptance. Safety. Interventions. Experience and knowledge. Communication.	**The cousequences for obstetrics.**	A necessary development. The affect on obstetric middle grades' workload. Junior doctors clinical experience.	**The consequences for the obstetricians**	Delegation of aspects of the obstetric role. Effect on the workload of obstetric middle grades. The clinical training of junior doctors.
Understanding of midwife practitioners' role	Lack of understanding. Supportive aspect of role.	**Acceptance and further development of role**	Separate role. Confidence and autonomy. Gynaecology work. Effectiveness of role. Training and monitoring. Understanding of midwife practitioner role. Further development.	**The effectiveness of midwife practitioner role.**	Safe practice. Effect on intervention levels. Communication. The gynaecological aspect of the role. Training and monitoring.	**Effectiveness of the midwife practitioner role.**	The effect on client care. Communication. Gynaecological aspect of the role. Training and monitoring.

APPENDIX – 13

Themes to organising concepts



APPENDIX – 14

JOB DESCRIPTION OF MPs IN THE CURRENT STUDY

JOB DETAILS

Job Title: Midwife Practitioner

Grade: **H**

Salary Scale:

Hours of Work: **37.5**

Department / Ward: **Maternity / Gynaecology**

Directorate: **Women and Children's**

Base:

ORGANISATIONAL/MANAGERIAL ARRANGEMENTS

Accountable to:

Managerially	1.	Head of Midwifery / Gynaecology Consultant Obstetric / Gynaecology lead
Reporting	2.	Head of Midwifery / Gynaecology Consultant Obstetric / Gynaecology lead
Professionally	3.	Director of Nursing

Responsible for:

Management of obstetric and gynaecological services, including bed management, within the department during the night shift, being responsible to the Head of Midwifery / Gynaecology and Lead Consultant Obstetrician / Gynaecologist..

JOB PURPOSE

- To provide leadership and direction to ward / departmental staff in monitoring the planning, delivery and evaluation of individualised care.
- To work directly with the Middle Grade Obstetrician on call, relieving Junior Doctors of inappropriate duties at night, by undertaking duties for which the postholder is competent, thus providing a service to patients within the extended role of the midwife/nurse practitioner.

DUTIES AND RESPONSIBILITIES

Management

The post holder will:-

Be responsible for the assessment of care needs and the development, implementation and evaluation of programmes of care.

Develop systems and processes to monitor:- quality of care; adherence to Trust policies and procedures; and clinical practice.

Deputise as necessary for Senior Midwives.

Maximise the performance of all staff within delegated areas ensuring effective structures for the supervision and direction of work.

Develop policies and practices across specialty in support of Clinical and Risk Governance agenda.

Be responsible for all aspects of the environment of care, developing standards, identifying risks and developing proposals for corrective action.

Manage clinical and non-clinical emergency situations including bed management within the department.

Be responsible for investigation of clinical incidents, complaints and professional issues.

Work directly with the Middle Grade Obstetrician on call

Fulfil the role of Supervisor of Midwives within the Trust, following successful completion of a training programme.

Leadership

The post holder will:-

Support the Head of Midwifery / Gynaecology with the implementation of the Trust Strategy for Nursing, Midwifery and Health Visiting.

To provide leadership and direction to ward / departmental staff in monitoring the planning, delivery and evaluation of individualised care.

Skills

The post holder will:-

Be responsible for the provision of expert nursing or professional advice.

Provide clinical expertise to the multi-disciplinary team particularly with regard to complex cases.

Provide specialist advice to the Head of Midwifery / Gynaecology and to other colleagues across the organisation and partner agencies.

Act in accordance with legal and statutory regulations in relation to practice and comply with policies and procedures.

Participate in service development within their specialty area to increase midwives confidence and expertise in increasing safe, normal childbirth.

To undertake advanced clinical practices including:

Venesection / venepuncture
Setting up / resiting intravenous infusion
Accepting and interpreting verbal prescriptions for medications and intravenous therapy
ECG
Intravenous drug therapy
Ventouse deliveries (following training)
Assisting at Caesarian Sections
Collaborative work in a multidisciplinary setting
Demonstrate an aptitude for creative / flexiible working patterns
Assist at gynaecological opreations
Deal with Gynaecology referrals directly from a variety of sources such as A & E, GP's
Undertake perineal suturing
Undertake prostaglandin induction of labour

Research

The post holder will:-

Initiate the directorate audit programme and utilise findings to promote a positive attitude towards the implementation of evidence based practice.

Education and Experience

The post holder will:-

Develop and facilitate training and awareness sessions relevant to clinical specialty in partnership with local education providers.

Provide formal and informal support to staff in which knowledge and skills are articulated and disseminated

Encourage staff to use the resources available to them, to promote a learning environment.

Identify and clarify the role of the Midwife Practitioner.

Evaluate and initiate change where appropriate to promote best practice.

Maintain a high standard of clinical skills and update practice as an ongoing activity.

Communication

The post holder will:-

Participate in key meetings within the directorate and develop mechanisms to cascade information to all areas within specialty.

Establish and develop good working relationships with key partners within the Local Health Board, neighbouring NHS Trusts, unitary authorities, voluntary sector, patients and public involvement to facilitate multi-disciplinary, multi-agency service delivery and development.

PERSON SPECIFICATION

Title: **Midwife Practitioner** **Grade:**

	ESSENTIAL	***DESIRABLE***	***METHOD OF ASSESSMENT***
QUALIFICATIONS	Registered Nurse and Midwife. Degree in relevant subject or working towards. Teaching/Assessing Module. Supervisor of Midwives, or eligible to become one	Masters degree Research Module. Management course ALSO course	Certificates
EXPERIENCE	Experience in both midwifery and gynaecology, of not less than 4 years in current practice. Working in wide range of clinical areas. Experience of teaching with the ability to teach at a range of levels. Clinically creditable with background in multi-disciplinary working. Substantial post registration experience including clinical leadership, team management and have a reputation for professional innovation and excellence with the ability to assume a leading role in the clinical care of women. Experience of establishing, developing and managing clinical services.	Experience of working within health and social service systems, both at local and strategic level. Evidence of teaching in practice environments	Application Form Interview References

ILLS	**Excellent communication skills – verbal and written.** Clear vision for best practice and positive management of change. Proven ability of practice development and innovation. An understanding of resource implications. Organisational and line management skills. Be able to initiate and participate in areas of clinical research.	Developing business cases. Presentation skills and confidence in AV use	Application Form Interview References
NOWLEDGE	Knowledge and understanding of clinical audit, effective research processes and application. Extensive knowledge and appreciation of national policies and standards. Knowledge of a range of contemporary issues relating to midwifery and gynaecology care	Evidence of lifelong learning, eg, portfolio Willing to pursue further studies and/or appropriate other scholarly activities	Application Form Interview References
PERSONAL ATTRIBUTES (*Demonstrable*)	Excellent negotiation skills. Ability to challenge. Work on own initiative. Team leader/motivator. Adaptable/flexible. Computer literate.		Application Form Interview References
INTERESTS			Application Form Interview References

OTHER (*Please Specify*)	Flexibility regarding working patterns.		Application Form Interview Document Check

e reviewed: **Reviewed by:**

ed by: Employee: **Agreed by: Manager**

e agreed: **Date agreed:**

May 2006

EXAMPLES OF OTHER MP JOB DESCRIPTIONS

DIRECTORATE OF WOMEN & CHILDREN'S SERVICES

JOB DESCRIPTION

JOB TITLE:	**GYNAECOLOGY MIDWIFERY PRACTITIONER (MID 14)**
GRADE:	**H**
LOCATION:	**DIRECTORATE OF WOMEN CHILDREN'S SERVICES**
PROFESSIONALLY ACCOUNTABLE TO:	**HEAD OF MIDWIFERY/WOMEN'S HEALTH SERVICES**
KEY WORKING RELATIONSHIPS:	**OBSTETRICIAN & GYNAECOLOGIST** **MIDDLE GRADE STAFF** **MIDWIFERY STAFF**
QUALIFICATIONS:	**REGISTERED MIDWIFE** **REGISTERED NURSE**

JOB SUMMARY

As an experienced midwife and nurse with a minimum of 5 years experience you will work within a multi-disciplinary team alongside the middle grade Obstetrician/Gynaecologist on -call and to provide expert specialist advice and support to midwifery and nursing colleagues. To cover the night duty shift over a 7-day period. There will be a requirement to work day duty as the service requires.

The post-holder is also responsible for providing professional and clinical leadership in the management of the Gynaecology/Maternity Services provision.

They will be required to work collaboratively with the night-nurse practitioners to ensure the in-patient pathway is appropriate to clinical need.

Competencies: Clinical Management

1. Analyses and interprets history, presenting symptoms, physical findings, and diagnostic information to develop appropriate differential diagnoses, Differentiates between normal, variations of normal and abnormal findings in the management of gynaecology and maternity clients.
2. Acts as the primary source of referral from GPs, other health professionals and co-ordinates admissions to both gynaecology and maternity wards.
3. Adequately assesses and intervenes to assist the patient in urgent or emergency situations,

- rapidly assessing the patients presenting problems, determining the appropriate referral to main sector medical staff.

4. Works within the NMC Scope of Professional Practice and Midwives Rules utilising advanced clinical skills in the process of care provision.
5. Takes a lead role in ensuring appropriate communication systems and collaborative working relationships between all members of the multi-disciplinary team, staff, patients and relatives
6. Acts as an expert resource in providing advice, support and assistance to midwifery/gynaecology staff in relation to patient needs.
7. Provides health promotion and disease prevention advice to patients. Provide appropriate psychological support for patients and their carers.
8. Establishes effective systems/processes for clinical supervision/mentorship for self and provides clinical supervision/mentorship to others.
9. Effectively supports ward nurses/midwives in managing patient care, assisting them in making decisions regarding care planning and prioritising of care.
10. Communicates information, care plans and results in a manner that preserves patient confidentiality, dignity and privacy and provides a legal record of care.
11. The postholder will be responsible for ensuring every effort is used to maintain high levels of infection control within the clinical setting, abiding to ..... NHS Trust Infection Control Policy.

Competencies: Leadership

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1. Leads the development and implementation of an effective out of hours advanced midwife practitioner service.
2. Links with Heads of Nursing, medical staff and key service managers to ensure the advanced midwife service.
3. Leads the development of the Advanced Midwife role and service in line with current best practice

   Leads where appropriate the developments of clinical guidelines, protocols and care pathways for acute care, in association with others.

4. Acts as a resource and professional role model for all professional staff.
5. Support midwives in their practice to increase confidence and skills in the management and clinical decision making required in normal childbirth.

Competencies: Education, Research and Development

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1. Actively participates in the education of staff ensuring that teaching is appropriate and tailored to meet individual and service needs. Identifies and takes every opportunity to develop the knowledge and skills of others.

2. Ensures own personal practice and professional development is planned and achieved in line with

PREP and Midwives Rules.

3. Effectively takes a lead role in identifying the service development needs in relation to Clinical Governance requirements, arising particularly from clinical risk, complaints, audit and Health and Safety. Assists in implementing safer systems of work.

4. Leads on agreed audit studies and initiatives/participates in research studies relevant to role in particular relevant NICE guidance.

5. Constantly evaluates the impact of the Advance Midwife Service, reporting regularly to key stakeholders. Constantly evaluates ways to improve the service, extending the boundaries of the role within acceptable limits.

6. Collects and collates clinical activity data to demonstrate service provision and inform service developments.

Competencies: Hospital/Patient Management

1. Effectively manages the hospital by night (or out of hours) providing senior clinical support to the on-call manager, and to on-site staff in dealing with staffing issues and untoward incidents in relation to obstetric and gynaecology services.
2. Actively contributes to the planning and management of services at Trust level by liaising with key

   managers and clinicians.
3. Deputise for core staff labour ward whenever required.
4. Contribute actively to all Directorate held management and professional forums.

All clauses to be included in the Job Descriptions of all staff, including medical staff, and where appropriate, expanded.

PERSON SPECIFICATION - Job Title: ADVANCED MIDWIFE

Criteria			*How Tested*		
Qualifications	**Essential** 4	**Desirable** 4	**Application** 4	**Interview** 4	**Presentation** 4
Registered Nurse/Registered Midwife	☐				
Diploma/Degree in health related subject		☐	☐		
Supervisor of Midwives		☐	☐		
Teaching Qualification		☐	☐		
Evidence of recent professional development	☐		☐		
Experience					
Minimum of 5 years post registration experience in either nursing or midwifery	☐		☐		
Significant recent experience in an acute speciality	☐			☐	
Evidence of leading teams	☐			☐	☐
Demonstrate autonomous working/decision-making	☐			☐	
Experience of participating in audit/research		☐		☐	☐
Significant multidisciplinary working experience	☐			☐	
Skills & Abilities					
Extended skills, e.g. cannulation, venepuncture	☐			☐	
Advanced patient assessment skills		☐		☐	
Excellent communication skills	☐		☐	☐	☐
Proven prioritisation skills	☐			☐	
Personnel management skill & experience	☐			☐	☐
Ability to contribute/present in meetings and other forum	☐			☐	☐
Excellent organisational skills	☐			☐	
Teaching skills and experience	☐			☐	
Personal Attributes					
Ability to work under pressure	☐			☐	
High level of personal integrity, with commitment to upholding values of the profession	☐			☐	

JOB DESCRIPTION

JOB DETAILS

Job Title: Senior Midwife, Clinical Practice

Grade: Band 7

Salary Scale: _____

Hours of Work: _____

Directorate: Child, Family & Community

Department: Maternity Services, including Theatres and Ward

Base:

ORGANISATIONAL ARRANGEMENTS

Accountable to: Head of Midwifery & Women's Services

Responsible to: Assistant Head of Midwifery

JOB PURPOSE

To work within a multi-disciplinary team alongside the middle grade Obstetrician on call, to provide expert advice and support to midwifery and nursing colleagues. To cover the night duty shift over a seven-day period, There will be the opportunity to work day duties as and when required.

QUALIFICATIONS:

- Registered Nurse (preferably with some gynaecology experience)
- Practising Midwife with a minimum of five years experience (at least two at F Grade or above)
- Health-related Degree (or working towards a degree)

KEY RESPONSIBILITIES:

Clinical and Professional Leadership

- Act as a resource in providing advice and support to midwifery staff, when deviation from normal progress during labour occurs
- Take calls from GP's/other health professionals and co-ordinate admissions to both the gynaecology/maternity wards
- Take a lead role in assessing and planning patient care appropriately, liaising with senior nursing/midwifery/medical staff.
- Effectively communicate with all staff/patients and their relatives. Provide emotional support to patients, e.g. when miscarrying.
- Support midwives in their practice to increase confidence in providing safe, normal childbirth when possible
- Support gynaecological staff in their work to promote safe, evidence-based practice
- To deputise for core staff - labour ward, whenever required
- Perform cannulation and venepuncture
- Administer intravenous infusions/drugs according to departmental protocols
- Assist the Registrar/Obstetrician in Theatre as First Theatre Assistant for all emergency gynaecology and obstetric surgery.
- Perform fetal blood sampling
- Develop basic ultrasound skills
- Perform perineal repair on the Labour Ward
- First point of call for any post-operative patients who become ill, i.e. chest pain; low blood pressure; distended abdomen
- Perform and evaluate ECG
- First point of call for all emergency admissions on the gynaecology ward, required to assist the registrar in making decisions and problem solving in relation to their management of care.
- Give advice and support to patients, A & E staff, surgical wards.

Quality and Care Standards

- Work collaboratively with midwives/nursing staff towards increasing evidence based care
- Ensure efficient and effective use of resources
- Monitor and maintain professional standards of care
- Take a lead role in developing evidence-based policies/protocols/guidelines which enable each practitioner to deliver safe and effective care
- Initiate and participate in clinical audit, supporting any recommended changes in practice
- Initiate and participate in any relevant research, promoting its use in everyday practice
- Ensure that risk assessments are regularly undertaken

- Actively promote all aspects of clinical governance

Education/Practice Development

- Identify areas of practice where staff may require training and development
- Take a lead role in developing midwifery practice
- Provide clinical support and teaching to both midwifery/nursing staff and medical staff (also to include students)
- Participate in teaching programmes to both medical and midwifery staff, including Induction Training and Obstetric Fire Drills
- To liaise with the Clinical Governance midwife when arranging any teaching/staff update sessions
- Ensure the clinical environment is one where learning is encouraged and promoted

Staff Development

- Undertake midwifery duties to maintain clinical credibility
- Identify own learning needs and ensure personal professional development
- Maintain own nursing and midwifery practice according to PREP/NMC requirements
- To undertake appropriate training to develop and enhance the role of the Clinical Practitioner

Health and Safety

- It is each individual's responsibility to perform only those duties which he/she is competent in undertaking. Relevant training will be initiated for the role, therefore at no time should an individual work outside their clinical competence
- Ensure compliance with .... NHS Trust mandatory training needs, e.g. Manual Handling, Health & Safety lectures, Fire lectures, Child Protection training
- Ensure all Trust policies and Health & Safety at Work Act is adhered to, safeguarding the safety of staff, patients and visitors.

PERSON SPECIFICATION - Post: Senior Midwife – Clinical Practice

ATTRIBUTES	ESSENTIAL	DESIRABLE	MEASURED BY
Experience:	Minimum of 5 years post-registration experience Practising midwife for last 2 years	Previous experience in gynaecology nursing Teaching qualifications Post-registration experience in all aspects of midwifery care Supervisor of midwives	Application form References Interview Personal portfolio
Education & qualifications:	Registered Nurse Registered Midwife Degree in Health related subject (or working towards)	Evidence of recent professional development/study Education to Masters Level (or working towards)	Application form Personal portfolio Interview
Skills & competencies	Advanced clinical skills – demonstrating an in-depth knowledge of low/high risk care Negotiation/assertiveness skills Proven ability to implement new policy/practices Evidence of leading practice development	Audit skills Research skills Risk management skills IT skills	Application form References Interview Personal portfolio Presentation
Personal attributes:	Ability to work as part of a team or alone Demonstrate initiative, drive and enthusiasm Flexible and reliable Excellent written/verbal communication skills Positive working relationships with all members of the multi-disciplinary team Ability to work under pressure and to accept responsibility		Application form References Interview Personal portfolio Presentation
Physical:	Fit and active Good health/attendance record		CV References Occupational health examination

APPENDIX – 15

midirs midwifery

PORTFOLIO

An exploration of midwives' perceptions about their role

Jacqueline Davies, Rachel Iredale

Objective: The study reported in this paper forms the first stage of a larger study about the effect of midwifery practitioner roles on the midwifery profession. The objective for this part of the work was to gain an understanding of how midwives perceive their role, with particular emphasis on the provision of intrapartum care.

Design: A qualitative study using focus group methodology. Seven focus groups were held with midwives (n = 48) from maternity units in Mid and South Wales.

Results: Four main themes emerged from the data; these were: essential midwifery functions in the intrapartum period, relinquishing aspects of the midwives' role, midwives' views of how they are perceived by others and the experience of midwives working in the NHS.

Conclusions: The main midwifery role in the provision of intrapartum care was perceived as being to ensure safe outcomes for both mother and baby, along with building trusting, supportive relationships with women and their birth partners. However, it appears that midwives' autonomy is restricted, not only by regulation, but also by the organisational systems of the NHS.

Implications for practice: Consideration should be given to lessening the constraints around midwifery practice and increasing autonomy.

Introduction

Historically, midwives provided care during childbirth for all women regardless of risk and, to some extent, circumstances. It is only comparatively recently, in chronological terms, that doctors, in the form of general practitioners and obstetricians, became involved in the more medical aspects of childbirth (Donnison 1988). With the advent of registration and supervision through the Midwives Act in 1902, restrictions were made on midwifery practice, which resulted in midwives being identified as those responsible for assisting women in normal childbirth with the express requirement on them to call for medical assistance where problems were detected. The passing of the Midwives Act 1902, along with other social changes, most particularly in the form of the National Health Service in 1948, changed the provision of midwifery care from one of personal appointment to a matter for the state, and as part of that, for its doctors. During the last century, obstetricians gradually increased their input and control over childbirth and the management and provision of maternity services. This was consolidated by the recommendations of the Peel Committee (Central Health Services 1970), which recommended 100% hospital births on the grounds of safety, although there was no apparent evidence for this (Tew 1990).

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In the early 1990s there were a number of reports that called for choice, control and continuity in maternity services (Welsh Health Planning Forum 1991, Department of Health 1993). Alongside this was a growing recognition by midwives that they needed to reclaim their role by working as the lead professional to provide overall care for women at low obstetric risk. However, some of the changes identified in government policy initiatives, especially with regard to the organisation of midwifery services, left many midwives dissatisfied with, and concerned about, their role (Sandall 1997, Ashcroft *et al* 2003). As a result many midwives have left the profession and recruitment continues to be increasingly difficult (Ball *et al* 2002). It appears from recent studies that not all of the changes which took place during this decade benefited midwives; indeed some have put undue pressure on them, which may be seen as having had a negative effect on the midwifery profession. Many midwives have felt unable to meet the demands placed upon them, which may have contributed to the recruitment and

retention problems currently being experienced in midwifery services.

Further changes were driven by the recommendations of policy documents such as *Midwifery: delivering our future* (DoH 1998), which suggested that midwives should develop their role in different ways, with some providing all care for women at low obstetric risk, while others should develop technical expertise to care for women at high obstetric risk alongside obstetricians. *Making a difference* (DoH 1999) opened the debate on innovations in practice and *Realising the potential* (National Assembly of Wales 1999) called for the development of existing, and the creation of new, career pathways for nurses, midwives and health visitors.

It would seem prudent, if midwives are to successfully develop their role in future years, to establish what midwives consider to be the key aspects of care which lie at the centre of their role and are essential to it. There may also be concerns that if midwives take on additional responsibilities they might do so to the detriment of other aspects of what is seen as care that should be solely undertaken by midwives. Therefore, the aim of this study was to gain an understanding of how midwives perceive their role, with a particular emphasis on the provision of intrapartum care.

Methods

Focus group methodology was employed in this study, as this method allows for the generation of data through group dynamics and interaction (Morgan 1988). This helps participants to explore and focus their opinions in a more effective way than would be possible in a one-to-one interview (Morgan 1988, Kitzinger 1995). The main advantage of using focus groups is that they are capable of producing rich data, while being flexible and inexpensive. The main disadvantages of this method is that the stronger, more opinionated members of the group may dominate discussions and influence other members, while others may not be comfortable in discussing their views and experiences in the public arena (Sim 1998). However, with respect to the planned study, the advantages of this method outweighed the disadvantages.

Purposive sampling was employed in this study to provide a homogeneous group, in that they all had knowledge and experience of providing intrapartum care. The more homogeneous the group members are, with regards to knowledge and experience, the more comfortable they are likely to be in contributing to the discussion (Sim 1998). Midwives were recruited from seven units in Wales, one rural, four urban and two metropolitan. These Trusts were chosen as they highlight both the variations in client population and the various types of provision of maternity services across Wales. The midwives were recruited by link midwives in the units and were from a variety of grades and experience in the provision of intrapartum care. Information sheets were given to prospective participants and written consent was obtained. The focus groups were held in private rooms within the hospitals and took place during the midwives' working hours. A topic guide was used to explore the following subjects:

- what participants thought women wanted from their midwife when they were in labour
- aspects of intrapartum care which should not be delegated
- perceptions of other health care providers and the public about midwives
- factors which had an influence on the midwives' role.

Although these were the main topics explored, the midwives were also encouraged to speak about aspects of their role which they thought important.

Ethical approval for the study was gained from the Multi-Centre Research Ethics Committee for Wales in 2003. Seven focus groups were held with groups of 5–10 midwives, who worked in a variety of settings across four NHS Trusts in Mid and South Wales. A total of 48 midwives participated in this study (Table 1). The researcher (JD) undertook the role of moderator and a co-researcher made written notes during the groups, which lasted approximately two hours. Data were analysed using thematic analysis. The focus groups were tape recorded and transcribed verbatim and imported into a computerised data analysis programme (NVivo), which was used to assist with the organisation of the text to enable analysis. During analysis both the dynamics of the group and the individuals within the group were regarded as being of equal importance (Morgan 1997). Consideration was given to asking participants to read the transcripts of the analysis in order to check their agreement with the interpretation of the data, but it was felt that this was an unacceptable demand upon their time. Instead, a co-researcher independently checked the coding of transcripts, in order to provide the researcher with the opportunity to discuss coding choices and consider other interpretations of the data (DePoy & Gitlin 1998). The names of participants have been changed before being presented in this paper to ensure confidentiality.

Results

The findings are presented in the form of description and comments from participants. Four main themes emerged from the study that highlight midwives' views about the essential aspects of their role, and which aspects should not be relinquished. The study also identifies midwives' views of how they are perceived, both by colleagues and the public, and their views about their experience of working in the NHS.

Midwives' perceptions of the essential midwifery functions in the intrapartum period

A number of issues were discussed concerning the important midwifery functions in the provision of intrapartum care, including ensuring the safety of the mother and baby, building a good supportive relationship with the woman and providing support for birth partners. When asked to identify the most important functions, the midwives

Table 1. Details of focus groups

	Location	Midwives	No of midwives
Group 1	Birth centre	Midwifery-led care midwives	5
Group 2	Birth centre	Midwifery-led care midwives	5
Group 3	Community hospital	Midwifery team leaders	9
Group 4	District General Hospital	Hospital and community midwives	10
Group 5	Community hospital	Community midwives	6
Group 6	District General Hospital	Hospital and team midwives	6
Group 7	District General Hospital	Hospital and community midwives	7

agreed that the most important issue was ensuring the safety of the mother and baby. The pursuit of normality was recognised, but it was felt that not all women were going to have straightforward labours and their job was to identify deviations from the normal and act upon these appropriately, while also knowing when to sit back and not interfere.

The midwives expressed the view that in order to help women through the process of childbirth, they have to know when women want to maintain control over the situation and when they want to hand that control over to the midwife. It was felt that as labour progresses women do not want to be confronted with a multitude of choices, they want the midwife to assume control and make the right choices for them. In order to successfully support women through labour, the midwives stated that it was essential that women felt confident in the midwives' ability to safely provide the care they need.

"I think confidence plays a big part in it, they need someone who is confident to instil confidence in them really... having somebody there who can help them through it and instil confidence in them is a big part of our job." (Joyce Group 1).

Generally, the midwives held the view that they were the most suitable professional group to build relationships and support women during labour, as opposed to obstetricians or obstetric nurses. Knowing what type of care is appropriate for women was seen as one of the challenges of the role. One midwife likened this skill to being a detective, in that there is a need to find out how a woman copes with pain and what type of care would best suit her personality. It was recognised that it is easier to build a relationship if the midwife has the opportunity to get to know the woman antenatally, but the ability to quickly establish rapport and build a relationship with the woman was seen as a fundamental component of the role.

"It's trying to get to know somebody in a short space of time... and to get the women to feel that you are on the same level, that you're looking out for them and then they put their trust in you ...." (Hannah Group 4).

The midwives expressed concerns as to whether husbands/partners were the best people to support women during labour, while acknowledging that men are now under a great deal of pressure to be present during the birth. The view was expressed that it can be difficult for men to accept labour as a normal, if painful, process, and as midwifery care often involves standing back and doing nothing unless problems occur, this can be interpreted by partners as the midwife doing nothing to ease the woman's suffering.

"...they need a lot of support, and as we do in normal midwifery we stand back and observe and they keep thinking, 'do something for her, give her something,' it's just getting them to understand, this is normal...." (Kay Group 6).

It was felt that if men are to be expected to support their partners there is a need to ensure that they also have a trusting relationship with the midwife.

Relinquishing aspects of the role

The second theme concerns midwives' views about relinquishing aspects of their role. Categories grouped under this theme include:

- jealousy and territorial attitudes
- the consequence of staff shortages
- the impact of midwife practitioner roles.

Concern was voiced that if aspects of their role were relinquished, it might result in midwives being expected to care for more than one woman in labour and the ideal of one-to-one care may possibly be lost. However, it was accepted that on occasion the inadequate number of midwives available to provide care resulted in the need to delegate the work of midwives and that this has now become an accepted way of providing care. When considering which aspects of their role they would be prepared to delegate in such circumstances, the view was that work should only be delegated if the activity in the unit warranted it. Some midwives felt that by delegating tasks to a health care assistant, they would be able to stay with the woman, thus improving care, but the opposing view was also voiced, that providing the more mundane tasks involved in caring for women allows the midwife more opportunity to build up the relationship between them. The midwives felt that if too many aspects of care were delegated it might pose a threat to their role. There was unease in some of the busier units that the consequence of staff shortages has meant that health care assistants sometimes took over aspects of care because the midwives did not have the time to do it all.

"I think it takes away some of the enjoyment of the job, cos I have worked in [name of unit] *and in that time I never bothed a baby, I never put a baby to the breast, cos they'd always get there first. The health care assistants had more time to do that and that is not right."* (Fiona Group 6).

The issue of whether there is a place for health care assistants was debated, and generally it was felt that care should be provided by qualified midwives, rather than untrained health care assistants. Midwives also expressed concern about medical staff interfering in normal childbirth. The midwives accepted the need for senior obstetricians to be present on the labour ward to support the junior medical staff, but felt that their role should be well defined and that they should not interfere in the care of women at low obstetric risk.

"You get her through and then you come to this pinnacle where she is actually going to give birth and then for them [obstetricians] *to come and remove that is almost taking something away from her as well, because they come in and destroy what you have built up."* (Judith Group 2).

However, the need to hand over care when problems arise was accepted without question.

Midwife practitioner posts were developed to carry out the role of the junior obstetric doctors. They work directly with middle-grade obstetricians, providing a service within the extended role of the midwife, by undertaking obstetric clinical practices. Midwife practitioners, where they have enhanced training to fulfil an extended role, have responsibility for planning care for women with complications. The midwives in the focus groups did not appear to have a great deal of understanding about midwife practitioner roles and felt that they did not have a big impact on their own role. Some midwives (n=8) felt that the development of midwife practitioner roles was a natural progression for the midwifery profession, but others (n=7) seemed unsure about the effect these roles would have on the profession and queried how far these posts would move away from normal midwifery.

"But is that midwifery? Are we breaching what midwifery is, you know to be with woman? I can see where it can be, but I don't know.... A lift out ventouse is not a big thing, but it is still outside the remit for some midwives." (Emily Group 7).

There was diversity of opinion among the midwives about these roles. The view was expressed that midwife practitioner posts have unjustified prestige and participants felt they were perceived as being superior to other midwifery posts. Some participants felt that midwives were being exploited for the benefit of the medical profession.

"You wonder if it is cost saving, it is cheaper to teach a midwife and you wonder how much advantage they are taking of you." (Joyce Group 2).

Conversely, the view was expressed that midwives should exploit the opportunities these posts provide to develop the midwifery profession and improve care for women. Others felt that midwife practitioners could help promote normality and reduce interventions and that their midwifery experience would make them more efficient than junior doctors.

Midwives' views of how they are perceived by others

The third theme explores midwives' views of how they are perceived by other health care professionals and clients and includes such issues as midwives being seen as difficult and elitist, being invisible and misrepresented and having to demonstrate their worth. The midwives expressed the view that other health care professionals had a poor opinion of midwives and that they were often described as being difficult and elitist. However, it was argued that sometimes midwives needed to become assertive in order to be advocates for women.

"If the SHO orders something regarding patient care and you don't think it is appropriate, you'll ask why they suggested it and we come across as being 'bolshie' and obstructive, but we are not, I mean there's ways of doing anything, and I think you can do it and get away with it, without getting a name for yourself, or you can be stroppy." (Dawn Group 4)

A number of midwives also felt that nurses resented the fact that midwives had a different title rather than just being regarded as nurses who specialised in a specific area and that nurses perceived midwives as being elitist. There were a number of comments made that the midwifery profession was far more advanced and had more autonomy than nurses. Notwithstanding this, many midwives expressed the view that they were not actually able to practise autonomously whereas, in some areas, nurses were increasing their level of autonomy. In spite of their image within the health service, it was recognised that often the general public do not understand what the midwives' role involves and that in the media they were either invisible or misrepresented. The general opinion was that the public still tended to think of midwives as nurses.

"I think there still is a misconception that midwives are nurses and obviously nurses assist doctors. Therefore, midwives are certainly not best placed to be delivering babies, because surely that is the doctors' job!" (Chloe Group 2).

Initially, some midwives felt that they did not need to explain their role, assuming that it was generally understood, but after considering this issue the view was expressed that this is probably incorrect. It was also felt that the private and personal nature of the role sometimes prevented midwives from discussing their work. There were many comments that the establishment of birth centres have made midwives more visible in the community and improved their image. However, there were also experiences from public protests when consultant-led units became midwife-led birth centres. This resulted in midwives feeling that they were still viewed as not being as good as obstetricians.

"Having been involved with the situation [the establishment of a birth centre] *and the public consultations there, it's an awful thing to say, but I think the public viewed us very much as second to obstetricians and that is very sad."* (Judith Group 2).

The experience of midwives working in the NHS

This theme explores the views and experiences of midwives working in the National Health Service in the UK and the factors influencing the role of the midwife, such as control and assimilation and cyclical changes.

An issue which caused a particular concern was the perceived pressure from medical staff, midwifery managers and, interestingly, from midwives themselves, to avoid changes to the system. The view was expressed that some senior midwives may resent and feel threatened by more junior midwives who are keen to take on more autonomous practice and responsibility. There appears to be a great deal of pressure to make midwives 'fit-in' to the system. These birth centre midwives discussed this issue and the fact that this pressure is not felt by midwives working in birth centres, where they feel they are allowed to be more autonomous.

"You would fit in after a while because you would get de-skilled...." (Anwen Group 1)

"You would either have to do that or you would leave and that is probably why so many midwives have left the profession in the last ten years, because either you knuckle down and get on with it or you do something else. We are lucky because we have this (birth centre), *whereas they perhaps haven't and end up getting out of the job."* (Joyce Group 1)

Many midwives mentioned that some midwives enjoy the excitement and drama of working in a hospital setting.

"Well I think a surprising number of midwives are prepared to be obstetric model type midwives, because [name of hospital] *are currently becoming midwifery led and there is a big divide among the staff, some think it is really positive and wonderful and others are absolutely dreading it and they really don't want to take on the holistic model of midwifery."* (Alison Group 1).

Midwifery managers also came in for a great deal of criticism from midwives, who felt that they did not understand the issues and difficulties of clinical practice. Midwives voiced their concerns that managers do not listen to what clinical midwives feel are the important issues, and that they maintain rigid control over midwives' practice. The opinion was also expressed that managers have unrealistic expectations of midwives. The hierarchical systems of the NHS were perceived as being responsible for placing additional pressure on midwives to conform. Generally the midwives felt they were answerable to too many people. This was felt to be the case even at ward level, where interference by ward and unit managers was regarded as having a negative effect on care.

The view was also expressed that if midwives are to promote normality there is a need to move away from the pressures of the hospital setting. It was felt that there was a 'blame culture' in operation in many hospital maternity units, which increased the pressure on midwives to conform. In addition, it was also felt that midwives did not support each other, as illustrated by this midwife.

"I have only been out on the community two years and prior to that, for the vast majority of my career, I've been a labour ward midwife. I now go back and work on the labour ward for our agreed days per month and I can honestly say the way some midwives look at you and speak to you infuriates me, it is insulting." (Mary Group 5)

It was mentioned that this often results in midwives feeling stressed and demoralised; this can have an impact on the retention of midwives which leads to reduced staffing levels, causing even more pressure. However, this lack of support from colleagues was only reported in the hospital setting. The view was expressed that community and birth centre midwives were far more supportive of each other.

The issue of the medicalisation of childbirth was discussed in detail. All of the groups felt that the reduced status and autonomy of midwives caused by the medicalisation of childbirth continues to be a current issue which impedes midwifery practice. The opinion was voiced that pressure from consumer groups has been beneficial to the development of the midwifery profession and that demands to normalise childbirth has resulted in midwives becoming accepted as the lead carer for women at low obstetric risk. However, it was acknowledged that consumer pressure has also resulted in unrealistic expectations about maternity care. The history of maternity services was described by midwives in most of the groups in terms of a circle or a pendulum, which has swung from midwives being the main providers of maternity care to a point where medical staff claimed control, and it was felt that gradually the pendulum was swinging back to the point where midwives have started to reclaim their role.

"Midwives shouldn't let that happen again for future midwives, or for the women, we shouldn't allow that to happen.... Perhaps we will all fight harder this time for it to never happen again." (Pam Group 2)

Discussion

Interpretation of data collected from focus groups necessitates checking the distinction between what participants feel is important and what they find interesting. In assessing how much emphasis a topic should receive, the researcher considered how many groups mentioned it, how many individuals within the groups mentioned it and how much enthusiasm it generated in participants. This has been described as *'group-to-group validation'* (Morgan 1997:63). However, if the researcher wants to know what participants regard as important they should ask, and Morgan (1997) suggests that this question needs to be built into the data collection tool. In this study, for example, when the participants were asked about the functions of midwives in providing intrapartum care, the discussion covered a range of subjects. However, when asked what were the most important functions, they were more likely to indicate subjects that they had not spent a great deal of time discussing, although there were others that they had appeared to find more interesting. It appeared that the importance of issues such as ensuring the safety of mothers and babies are accepted unquestioningly, thus the midwives did not see any benefit in discussing these in great detail. While other issues, such as providing support for birth partners, were seen as sometimes frustrating and difficult to deal with, and the midwives enjoyed discussing their shared concerns and methods of dealing with this.

The midwives held the view that women need to see that their midwife can provide safe care and is confident in her manner and actions. The midwives felt that part of their role is to take control of the situation during labour and to act as an advocate for women. Although this can be partially justified, as childbirth is a life-changing event (Raphael-Leff 2001), these midwives did not perceive that taking control over women's decisions and choices in labour could actually be viewed as inappropriate. Bluff and Holloway (1994) found that women followed the midwives' advice and did not challenge their decisions, even when this differed from what they had originally wanted. This may have been because they trusted the midwife and wanted her to take control. However, this study found that many women wanted to be involved in choosing the type of care they received, but did not know how to communicate this to the midwives. Lavender (1999) found that women wanted to maintain control and to be involved in making decisions about the care they received.

The midwives did, however, acknowledge the importance of trying to find out what type of care women wanted, which suggested that they wanted to meet the women's needs (Sinivaara *et al* 2004). Overall, the midwives expressed the view that it was their role to ensure that women are supported and given appropriate care, during what is likely to be one of the most important experiences of their lives. In addition, it was felt that this had been extended to providing support to partners and the need was highlighted for midwives to assess the partner's needs as well as the woman's (Somers-Smith, 1999, Eames 2004).

Midwives felt that they were viewed, by both doctors and nurses, as being elitist and sometimes difficult to work with. The view was expressed that this may be the result of having to act as advocates for women to ensure they receive appropriate care. However, the midwives did not appear to be concerned about their image and felt that it sometimes resulted from envy. This attitude may be problematic at a time when there is a need for multidisciplinary working, as recommended by such documents as *The National Service Framework for children, young people and maternity services in Wales*, (Welsh Assembly Government 2005). Outside of the health service it appears that there is a lack of understanding about the role of the midwife. The midwives recognised that assumptions that clients understand the midwives' role and function are not always correct, as identified by Leach *et al* (1998). There was, however, a degree of optimism expressed that the image of midwives was improving and that midwives were beginning to be seen in a more positive light, as their visibility in the community increases.

Staffing shortages in midwifery have resulted in midwives having to delegate aspects of their role. Midwives resented having to do this but recognised that it was unavoidable. It seems that midwives jealously guard their role, which would appear to result from the fact that they find caring for women during labour and helping during the birth to be both rewarding and fulfilling. There was concern that if the enjoyable aspects of care were delegated then midwifery practice might consist only of the less rewarding aspects of providing care, thus reducing job satisfaction and exacerbating recruitment and retention difficulties. The view was expressed that consideration should be given to which aspects of their role are delegated, in order to ensure that it is not eroded.

There appears to be considerable pressure upon midwives, mainly in the hospital setting, to 'fit in' with the system. This may reflect the conflicting ideologies of practice outlined by Hunter (2004). Although midwives describe themselves as being autonomous practitioners, there appears to be pressure not to try and change the system, which may reflect the fact that many midwives are not comfortable about undertaking a more autonomous role (Pollard 2003). The hierarchy of the NHS may pressurise staff to conform and work under strict controls and the midwives reported experiencing stress and low morale, which may result in an exacerbation of recruitment and retention problems (Ball *et al* 2002). The issue of midwives' dissatisfaction with their role has been highlighted in other studies (Sandall 1997, Kirkham 1999, Deery 2005).

In conclusion, although this aspect of the study achieved its objective in gaining an understanding of how midwives perceive their role, the findings were not specific to the midwives' role in the provision of intrapartum care. Most of the midwives who participated in this study work in more than one clinical area and they used their full range of experiences when discussing their role. Many of the views expressed were controversial, such as the view that women want to hand over control to midwives during labour and the issue of the current difficulties of working in the NHS, yet the midwives felt quite comfortable about expressing them. This may have resulted from the fact that the midwives in each group knew each other and there was a degree of commonality in that they shared the same professional background. This appeared to give them the confidence to express their views openly. The fact that the researcher is employed as a midwifery manager might have suppressed the expression of such frank opinions, but the power of 'belonging' appeared to override this to give the midwives the opportunity to raise and discuss the issues and frustrations they felt were important in clinical practice.

It would seem from the findings of this aspect of the study that midwives have a clear understanding about their role and which aspects they would not want to lose. However, it seems that, currently, midwives, with the exception of those working in birth centres, are unhappy with the constraints of their working lives. Although the findings of this initial part of the study do not relate specifically to the provision of intrapartum care, they do provide a baseline understanding about the role of the midwife, which will allow the next stage of the study, the effect of midwife practitioner roles on the midwifery profession, to be explored in context.

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